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ABSTRACT

The supply of physicians in the United States and the way in which physician graduate medical education programs are established are discussed. Too many physicians are being trained within certain specialties and too few are being trained as primary care physicians. No system exists for ensuring that the number and types of physicians being trained is consistent with the approximate number needed. Federal agencies that directly or indirectly support graduate medical training programs make little effort to coordinate the numbers and types of those being trained. There is disagreement among medical organizations on the need to control physician specialty distribution. It is suggested that the Secretary of the Department of Health, Education, and Welfare (HEW) should discuss with the Coordinating Council on Medical Education the possibility of engaging in national studies of physician supply and requirements. HEW's Graduate Medical Education National Advisory Committee should play an active role in determining the scope of these studies and in monitoring their progress. The committee should also review in-depth the Coordinating Council's completed studies and provide the Secretary with its detailed comments and recommendations. (SW)

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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Are Enough Physicians Of The Right Types Trained In The United States?

There appears to be some agreement within the medical profession regarding the need to train more primary care physicians in the United States. This view is not based upon any particular study but rather on observations by people in the health care field. Opinions differ as to what constitutes a sufficient supply of specialists and whether too many of certain specialists are being trained. While total number of practicing physicians has increased dramatically during the past decade and will continue to do so, questions still remain as to whether there are enough or too many.

The Secretary of HEW should discuss with the Coordinating Council on Medical Education the possibility of engaging in national studies of physician supply and requirements, including physician extenders, under some mutually agreeable contractual arrangement. HEW's Graduate Medical Education National Advisory Committee should (1) play an active role in determining the scope of these studies and in monitoring their progress and (2) review indepth the Coordinating Council's completed studies and provide the Secretary with its detailed comments and recommendations.

U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

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UNITED STATES GENERAL ACCOUNTING OFFICE

HRD-77-92
MAY 16, 1978

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(5)

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the supply of physicians in the United States and the way in which physician graduate medical education programs are established. It discusses the roles of the medical profession, States, and various Federal agencies in training appropriate numbers and types of physicians. The report contains a variety of views on whether the country has an adequate supply of physicians by specialty and whether additional Federal regulation is needed to insure that appropriate numbers and types of physicians are trained.

Our review was made because of increasing concern and debate over the adequacy of the supply of physicians in the United States, the substantial commitment of Federal funds for training physicians, and the importance of this issue to the overall health of the American people. We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget; the Secretary of Health, Education, and Welfare; the Secretary of Defense; the Chairman, Federal Trade Commission; and the Administrator of Veterans Affairs.

Elmer B. Staats
Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

ARE ENOUGH PHYSICIANS OF THE RIGHT TYPES TRAINED IN THE UNITED STATES?

DIGEST

Little is being done in the United States to match the training of its future physicians to the medical needs of the country. Under the present medical educational system, it appears that too many physicians are being trained within certain specialties and too few are being trained as primary care physicians. Many professional medical organizations believe their essential responsibility is to train quality physicians. They do little to determine if the numbers of various types of physicians they train are appropriate to the needs of the country. In fact, most medical organizations do not appear to have the data necessary to make these decisions. It is apparent that substantial changes are required to balance the numbers of physicians trained in various specialties with national requirements.

Obviously, determining the appropriate numbers of physicians needed by specialty and in aggregate is not an easy task. The Congress can aid in this process by working with the President to develop a clear national health policy. To the extent that the Congress and the President can clearly articulate their intent to develop and support health programs, and the kind and level of support to be provided, projections of physicians required will be somewhat easier.

THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT

GAO attempted to obtain information from the medical profession on the optimal number

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of physicians needed in each specialty. GAO also focused on the trend in educating physician specialties and the activities and involvement of medical organizations, medical schools, teaching hospitals, Federal agencies, and State legislatures and offices of higher education in training appropriate types of physician specialists to meet national needs.

Federal assistance in the education of health professionals generally dates from the Health Professions Educational Assistance Act of 1963. Assistance is provided through grants and awards to institutions and loans and scholarships to financially needy students. Health professions education assistance obligations for fiscal years 1965-77 amounted to about $4.0 billion; of this $2.3 billion, (57 percent), was for medical schools and students.

The health professions legislation expired June 30, 1974, but funding was provided by continuing resolution until new authorizing legislation was approved on October 12, 1976. As enacted, this legislation--the Health Professions Educational Assistance Act of 1976 (Public Law 94-484)--extended the health manpower training authorities through fiscal year 1980 with significant changes to meet national needs. This act is designed primarily to produce more primary care practitioners and improve health services in manpower shortage areas.

ADEQUACY OF SUPPLY OF PRIMARY CARE PHYSICIANS

The view within the medical profession that a need exists to train more primary care physicians is not based on a comprehensive study of need but rather on

--statistics showing a steady decline in the percentage of practicing physicians engaged in primary care since 1931;

- --comparisons with the number of practicing primary care physicians in other countries, notably the United Kingdom where more than 75 percent of all physicians are in primary care; and

- --observation that a primary care physician can treat the vast majority of problems for which people seek care.

However, there appears to be some question as to the number of primary care physicians and physician assistants needed. Also, there is not enough data showing the type and extent of patient care services actually provided by specialists. (See p. 9.)

Recent changes in graduate medical education, particularly in family practice, have begun to affect the number of primary care physicians. Specifically, the percentage of filled graduate medical education training positions in the primary care specialties--which had declined from 1950 to 1970--began to increase after 1970. This was due chiefly to the development and expansion of family medicine training programs. (See pp. 13 and 14.)

ADEQUACY OF SUPPLY OF OTHER PHYSICIAN SPECIALISTS

While there is apparent need for more primary care physicians, studies have suggested that too many students are being trained in specialties, such as surgery, cardiology, neurosurgery, and urology. (See p. 22.)

However, none of the medical professional organizations GAO contacted were of the opinion that an excess supply of physicians exist within their specialty. Most expressed the opposite view. But only half these organizations could estimate an appropriate physician-to-population ratio for their specialty which could provide the basis for estimating approximate number of additional physicians needed. Many based their opinions on professional experience or judgment, not on scientific studies. (See p. 27.)

ADEQUACY OF AGGREGATE NATIONAL SUPPLY OF PHYSICIANS

Considerable debate continues over whether a sufficient aggregate supply of physicians exists in the United States. Studies in recent decades relied on physician-to-population ratios for estimating needs. These varied with each group performing a study. Some believe there are not enough physicians in the Nation. Others believe the country may soon be producing more physicians than it needs.

After examining the situation, GAO concludes that a reasonably accurate determination can be made on the question of supply only after the number of specialists and subspecialists required to meet national needs has been determined. (See p. 32.)

GRADUATE MEDICAL TRAINING PROGRAMS--LITTLE REGARD TO NATIONAL NEED

No system exists for insuring that the number and types of physicians being trained is consistent with the approximate number needed. Instead, decisions on the types and sizes of graduate medical training programs are usually made by individual program directors in hundreds of medical schools and hospitals based on the availability of funds, the need to provide balanced training within a medical school, and the patient care needs of training institutions. (See p. 39.)

The Veterans Administration (VA) and Departments of Defense and Health, Education, and Welfare support either directly or indirectly many graduate medical training positions. Each of these agencies meet their own objectives, making little effort to coordinate the numbers and types of those being trained through its agency with those trained by other agencies or the private sector. (See p. 46.)

In addition, the VA by law is moving to increase the number of medical schools and the aggregate supply of physicians at a time when concern is growing that the United States may soon have too many physicians. (See p. 47.)

DISAGREEMENT ON THE NEED TO CONTROL PHYSICIAN SPECIALTY DISTRIBUTION

Many medical organizations are responsible for dealing with policy matters affecting medical education, accreditation of graduate training programs, and certification of physicians choosing to practice in a given specialty, but none of them have been given, or has assumed, overall responsibility for seeing that the types of physicians in each specialty are trained in appropriate numbers. (See p. 56.)

A majority of these medical organizations approached by GAO believed that control or regulation of the graduate medical education process is unnecessary because the appropriate numbers and types of physicians could be achieved through the law of supply and demand. (See p. 60.)

Offsetting this view, most program directors responsible for establishing and operating graduate medical training programs which were contacted by GAO, believe some control of the graduate medical education process is needed. (See p. 60.)

Most medical organizations contacted believe that if control or regulation of graduate medical education is undertaken, it should be exercised by the medical profession, through the Coordinating Council on Medical Education. (See p. 61.)

RECOMMENDATIONS TO THE SECRETARY OF HEW AND ADMINISTRATOR OF VETERANS AFFAIRS

The Secretary, HEW, should meet with representatives of the Coordinating Council on Medical Education and explore the possibility of its engaging in national studies of physician and physician extender manpower supply and requirements under a mutually agreeable contractual arrangement. HEW's Graduate Medical Education National Advisory Committee should (1) play an active role in determining the scope of these studies and in monitoring their progress and (2) review indepth the Coordinating Council's completed studies and provide the Secretary with its detailed comments and recommendations. (See pp. 81 and 82.)

Upon completing these studies, HEW and the Coordinating Council should attempt to reach some mutual agreement on health manpower supply and requirements to provide a reasonably accurate assessment of the Nation's present and future need for various types of physicians and physician extenders and develop recommendations to achieve desired goals. Further, HEW should

--publish the results of these analyses and make them available to congressional committees, the public, and components of the medical profession.

--Encourage medical schools and teaching hospitals to make appropriate adjustments in the size of their residency training programs, where imbalances are determined to exist, and

--monitor voluntary efforts by the medical profession to achieve the desired goals through its Graduate Medical Education National Advisory Committee.

If voluntary actions by the medical profession do not achieve the desired results of eliminating imbalances in graduate medical training programs and positions, within a reasonable time, HEW should seek appropriate legislative action. (See p. 82.)

While these studies are being conducted, the Secretary should continue to emphasize funding those graduate education training programs leading to the development of additional numbers of primary care physicians and the Administrator of Veterans Affairs should continue to emphasize general internal medicine training. (See p. 83.)

RECOMMENDATIONS TO THE CONGRESS

When the Department of Health, Education, and Welfare and the Coordinating Council on Medical Education have developed a reasonably accurate assessment of the approximate number of physicians required in each specialty and subspecialty to meet national needs and have compared this assessment with the number currently in practice and in training, they will be able to estimate the number of first-year graduate medical education training positions needed in the Nation.

Should the total number of needed first-year graduate training positions be greater than the number of physicians annually graduating from medical schools in the United States, the Congress should consider whether

--additional medical schools should be established or the capacity of existing medical schools should be increased or

--the shortage should be filled by U.S. citizens studying abroad or by medical graduates from other countries.

On the other hand, if total number of needed first-year graduate medical education training positions should be fewer than the number of physicians annually graduating from U.S. medical schools, the Congress should explore the extent to which Federal financial assistance for increasing the number of medical school graduates is necessary and should be continued.

Until the overall need for additional physicians is more precisely determined, the Congress should explore whether it wants the Veterans Administration to continue providing Federal grants either to establish new medical schools or increase the capacity of existing ones, as provided under Public Law 92-541. (See p. 84.)

COMMENTS BY MEDICAL PROFESSIONAL ORGANIZATIONS, THE FEDERAL TRADE COMMISSION, THE DEPARTMENT OF DEFENSE, HEW, AND VA

GAO asked the Coordinating Council on Medical Education and its constituent agencies along with HEW, VA, the Department of Defense and the Federal Trade Commission to comment on its draft report. Their responses are included as appendixes to this report.

Generally, the reaction by the medical profession was mixed. Most organizations agreed more information was needed on which to base future physician manpower estimates. However, most medical organizations indicated they were against any Government control or regulation to assure the training of appropriate numbers and types of physicians. They believed that the Coordinating Council's authority to accredit graduate medical education programs should not be used to regulate the number or type of specialists being trained.

Some of these organizations felt the laws of supply and demand would take care of any imbalances. One organization indicated that the report did not establish any deficiencies or flaws in the present system of physician distribution based on responses by the medical profession to GAO's questions. Consequently this organization saw no need for any form of control.

The reaction was also mixed to GAO's proposal that studies be undertaken to determine appropriate physician-to-population ratios for use in assessing the adequacy of supply of the various types of physicians. While the Coordinating Council on Medical Education believes GAO's approach was overly simplistic and inadequate, it believes that the Nation's needs for various kinds and numbers of physicians may be analyzed within reasonable limits.

The Federal Trade Commission's Bureaus of Economics and Competition took the position that strong recommendations for drastic action should not be issued without substantial further analysis and suggested that the report go no further than recommending a detailed study of the Nation's health needs. It also stated that selecting the Coordinating Council for this study would raise serious conflict of interest issues.

HEW did not agree with GAO's proposal that the Coordinating Council assume responsibility for developing and implementing a system to see that the number and types of physicians trained are consistent with the approximate number needed. Instead, HEW looks to its Graduate Medical Education National Advisory Committee which was given responsibility by the Secretary to accomplish most of these objectives.

In the draft report GAO proposed that HEW determine the number of physician extenders needed in the Nation and that the Coordinating Council should consider their impact on the number and types of physicians needed. HEW agreed. However, HEW pointed out that requirements for physician extenders cannot be determined in isolation from the requirements for physicians and that its Advisory Committee has indicated it will consider this matter.

HEW agreed to continue to emphasize funding those graduate training programs leading to the development of additional primary care physicians while the physician manpower studies are conducted.

The Veterans Administration stated it will also continue to expand internal medicine residency training programs and further support the national consensus for more primary care physicians. In addition, VA said it plans to request deletion of its legislative responsibility to support new medical schools and expand existing ones. The Department of Defense had no comments on the draft report.

In response to these comments, GAO is no longer proposing that the accreditation process be used as a means for seeing that appropriate numbers and types of physicians are trained in each specialty. GAO agrees that requirements for physician extenders should not be determined in isolation from the requirements for physicians. Moreover, GAO believes that the profession should be allowed a reasonable period to demonstrate it can bring about necessary change.

GAO still believes the Coordinating Council on Medical Education is in the best position to study the problems of physician specialty distribution and believes that the Coordinating Council should also determine the number of physician extenders needed in connection with its study of the number of physicians needed.

GAO further believes the concerns of the Federal Trade Commission relating to possible conflict of interest could be overcome by having HEW's Graduate Medical Education National Advisory Committee (1) play an active role in determining the scope of these studies and monitoring their progress and (2) review indepth the Coordinating Council's completed studies and provide the Secretary with its detailed comments and recommendations.

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ABBREVIATIONS

AAFP	American Academy of Family Physicians
AAMC	Association of American Medical Colleges
ABMS	American Board of Medical Specialties
ACS	American College of Surgeons
ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
AHA	American Hospital Association
AMA	American Medical Association
CCME	Coordinating Council on Medical Education
CMSS	Council of Medical Specialty Societies
DO	Doctor of Osteopathy
DOD	Department of Defense
FTC	Federal Trade Commission
GAO	General Accounting Office
GMENAC	HEW's Graduate Medical Education National Advisory Committee
HEW	Department of Health, Education, and Welfare
LCGME	Liaison Committee on Graduate Medical Education
MD	Doctor of Medicine
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
VA	Veterans Administration

GLOSSARY

Primary care physicians - In our report this refers to general practitioners, family practitioners, general internists, general pediatricians and general

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CHAPTER 1

INTRODUCTION

In the United States, medical education usually begins with 3 to 4 years of general college or university studies followed by 4 years at a medical school. For graduates wishing to specialize, this is followed by several years of graduate medical education training, generally in a hospital setting.

Certification in a given specialty is obtained by satisfactorily completing a program of graduate education, training, and practice and by passing an examination developed and administered by a national board representing the specialty involved.

The training of physicians in the United States is carried out in 136 school. of medicine and osteopathy and in nearly 1,700 teaching hospitals.

ORGANIZATIONS INVOLVED IN GRADUATE MEDICAL EDUCATION

The policymaking, accreditation, and certification bodies in medical education are a group of medical professional organizations that have banded together since 1972 to establish a voluntary mechanism to coordinate and direct the accreditation at all levels of medical education. The organizations and their roles are discussed below.

Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education

The Coordinating Council on Medical Education (CCME) was established in 1972 by five sponsoring medical organizations: the Association of American Medical Colleges (AAMC), the American Board of Medical Specialties (ABMS), the Council of Medical Specialty Societies (CMSS), the American Hospital Association (AHA), and the American Medical Association (AMA). CCME membership is comprised of three members from each of the five sponsoring organizations along with one public and one Federal representative.

CCME is responsible for reviewing matters affecting all levels of medical education and recommending policies to its five sponsoring organizations for their approval. The CCME was established in an effort to

--rationalize the graduate medical education system,

--make the educational aspects of training predominate over its service aspects, and

--make the distribution of specialties more responsive to the needs of the American people.

According to AMA, the objectives from the Bylaws of the Coordinating Council read as follows:

(a) "This Council shall provide a forum for the members of the agencies represented to discuss and develop policies on all issues related to medical education and to initiate the necessary steps for their consideration by the five (5) parent organizations.

(b) This Council shall supervise and coordinate the activities of (1) the existing Liaison Committee on Medical Education (undergraduate), (2) the new Liaison Committee on Graduate Medical Education, (3) such other liaison committees related to medical education as being mutually agreeable and advisable by the five parent organizations and the CCME."

It should be noted that before matters become official CCME policy, they require the review and unanimous approval of its five sponsoring organizations.

The Liaison Committee on Graduate Medical Education (LCGME) was established as (1) the accrediting body for graduate medical education (residency) programs and (2) the body to develop the most effective methods to evaluate graduate medical education, to promote its quality and to deal with such other matters relating to graduate medical education as appropriate. LCGME began to function as the recognized body for accreditation of graduate medical education programs on January 1, 1975. Policies developed by LCGME must be reviewed by the CCME and have the unanimous approval of its five constituent organizations.

LCGME accredits graduate medical training programs based on the review and recommendation of the appropriate residency review committee. The role of the committee and the other medical organizations is discussed in appendix I.

FEDERAL SUPPORT FOR HEALTH MANPOWER EDUCATION

Before 1960, Federal support for the education of health manpower was piecemeal. At that time, reports commissioned by the Department of Health, Education, and Welfare (HEW) and the Congress concluded that immediate steps were needed to increase the Nation's output of physicians.

By enacting the Health Professions Educational Assistance Act (Public Law 88-129) of 1963, the Congress established the first Federal program directed at meeting critical needs for physicians and certain other professional health manpower, and provided financial assistance to schools for construction of facilities and assistance to students in the form of loans. The scope of this legislation was broadened in 1965 and 1968.

Major amendments were passed by the Congress as part of the Comprehensive Health Manpower Training Act of 1971 (Public Law 92-157). This legislation was designed to establish an explicit Federal role regarding support for the education of physicians and other health profession manpower. In addition to providing support for construction, special projects, and institutional and student assistance, this legislation made fundamental modifications and additions to health professions education assistance programs. This legislation was aimed at increasing the supply of physicians and other health professions personnel, among other things, while stabilizing the finances of health professions educational institutions.

The Comprehensive Health Manpower Training Act of 1971 for the first time specifically provided for special project grants to help address two problems--geographic and specialty distribution of physicians and other health professions personnel. One of the special projects dealing with specialty distribution was a grant program for hospitals to operate approved graduate medical training in family medicine and to provide stipends to physicians enrolled in such programs.

The health professions legislation expired on June 30, 1974, and new authorizing legislation was approved October 12, 1976. As enacted, the Health Professions Educational Assistance Act of 1976 (Public Law 94-484) extends the health manpower training authorities through fiscal year 1980 with significant changes to meet national needs. This act is designed primarily to produce more primary care practitioners and improve health services in manpower shortage areas.

Section 2 of the Health Professions Educational Assistance Act of 1976 states in part that the Congress finds and declares that

--health professions personnel are a national health resource and the Federal Government shares the responsibility of assuring that such personnel are available to meet the health care needs of the American people;

--it is therefore appropriate to provide support for the education and training of such personnel, and at the same time it is appropriate to provide this support in a manner which will assure the availability of health professions personnel to all the American people;

--the availability of high quality health care to all Americans is a national goal and is, to a substantial extent, dependent on the availability of qualified health professions personnel and the availability of adequate numbers of physicians engaged in the delivery of primary care and in the various specialties, but numbers which do not exceed the need for physicians in such specialties; and

--physician specialization has resulted in inadequate numbers of physicians engaged in the delivery of primary care.

Accordingly, this act requires medical schools to provide annually an increasing percentage of their graduate medical training positions for individuals in the primary care specialties as a condition for receiving capitation grants beginning in fiscal year 1978.

In addition, the act authorizes grants to schools of medicine and osteopathy to establish and maintain academic administrative units to provide clinical instruction in family medicine and continues Federal assistance (stipends) to physicians enrolled in family medicine training programs. The act also authorized assistance to plan, develop, and operate approved graduate medical education training programs in internal medicine or pediatrics that emphasize training for practice in general internal medicine or general pediatrics and authorizes traineeships and fellowships to physicians participating in these programs.

LEVEL OF FEDERAL FUNDING

From a $110.2 million authorization in fiscal year 1965, the health professions educational assistance program grew to an authorization of about $578 million and appropriations of about $409 million for fiscal year 1977. (See table on p. 5.)

Health Professions Education Assistance Obligations by Type of School and Program for Fiscal Years 1965-77 (note a)

Type of school or entity	Cons-truction	Capi-tation	Special projects	Student loans	Scholar-ships	HMEIAs (note b)	Other programs (note c)	Total	Percent of total
	(millions)								
Health profession schools:									
Medical	$ 801.8	$ 614.1	$306.6	$177.5	$151.7	$123.4	$85.7	$2,260.8	57.1
Osteopathy	28.5	37.1	9.3	11.1	9.4	.2	6.7	102.3	2.6
Dental	247.0	238.2	69.7	73.9	25.2	7.4	22.1	683.5	17.3
Optometry	17.5	19.3	15.2	11.5	3.7	.9	1.1	69.2	1.7
Pharmacy	31.4	110.3	15.3	38.2	27.1	1.1	2.1	225.5	5.7
Podiatry	10.4	9.9	9.3	4.3	1.5	.3	3.0	38.7	1.0
Veterinary medicine	77.4	45.1	4.8	14.4	4.7	1.2	2.2	149.8	3.8
Public health	30.1	-	1.8	-	-	2.7	-	34.6	.9
Nursing	15.8	-	18.3	26.3	27.7	.3	34.3	122.7	3.1
Allied health	4.8	-	47.6	-	-	.1	1.9	54.4	1.4
Subtotal	1,264.7	1,074.0	497.9	357.2	251.0	137.6	159.1	3,741.5	94.6
Other entities:									
Hospitals	-	-	-	-	-	3.7	93.3	97.0	2.5
Colleges and universities	-	-	-	-	1.1	47.5	24.6	73.2	1.8
Associations and foundations	-	-	1.5	-	-	13.7	.5	15.7	.4
Other	-	-	2.2	-	-	26.8	1.5	30.5	.8
Subtotal	-	-	3.7	-	1.1	91.7	119.9	216.4	5.5
Total	$1,264.7	$1,074.0	$501.6	$357.2	$252.1	$229.3	$279.0	$3,957.9	d/100.1

a/The existing accounting system of HEW's Bureau of Health Manpower does not capture health manpower obligations by the various disciplines. Therefore, the Health Professions Education Assistance Obligations are based on HEW's professional judgment estimates.

b/Health Manpower Education Initiative Awards.

c/Family medicine, primary care, financial distress, foreign medical transfers, Health Professions Start-up grants, Health Professions Conversion grants, HEW's Graduate Medical Education National Advisory Committee, manpower supply and distribution studies, Emergency Medical Services, D.C. Medical/Dental Act. (includes contracts to health professions schools, i.e., medical, osteopathic, dental, veterinary, optometry, podiatry, pharmacy), and to nonprofit organizations.

d/Percents do not total 100 due to rounding.

Source: Bureau of Health Manpower, HEW.

Health professions educational assistance obligations for the fiscal years 1965 to 1977 amounted to about $4 billion. About $2.3 billion, or 57 percent, of this assistance was for medical schools and students primarily in the form of construction assistance, capitation grants, special projects, student loans and scholarships, and health manpower education initiative awards. (See p. 6.)

Health Professions Educational Assistance Authorizations, Appropriations, and Obligations for Fiscal Years 1965-77

Fiscal year	Authorizations (note a)	Appropriations	Obligations (note b)
	(millions)		
1965	$ 110.2	$ 113.3	$ 96.5
1966	85.4	104.6	97.9
1967	225.0	199.2	167.8
1968	245.0	255.3	220.3
1969	255.0	173.4	228.5
1970	322.0	270.1	276.2
1971	428.0	303.1	295.7
1972	754.5	443.1	318.5
1973	896.5	447.6	420.8
1974	1,049.4	481.6	502.8
1975	Continuing Resolution	423.5	374.8
1976	Continuing Resolution	276.0	550.8
Transitional Quarter	Continuing Resolution	50.0	400.0
1977	577.7	408.8	407.3
Total	$5,557.7	$4,348.7	$3,957.9

a/Excludes authorization figures not specifically stated in the legislation, such as scholarships (i.e., programs and appropriations authorized but levels not specified). Therefore, some fiscal years may reflect appropriations above the amounts authorized.

b/Obligations are generally reflected in the year in which they occur, and in some programs (such as construction) appear in a year, or years subsequent to appropriations. In addition, a portion of the 1973 funds released in December 1973 are reflected in 1974.

Source: BUREAU OF HEALTH MANPOWER, HEW

SCOPE OF REVIEW

We conducted our review at the headquarters offices of HEW, the Veterans Administration (VA), and the Department of Defense (DOD), and at 16 medical schools and 33 teaching hospitals with graduate medical training programs. Through discussions with medical school and teaching hospital officials, we attempted to determine, among other things, the criteria and factors influencing decisions on the number and types of physicians being trained and whether a coordinated approach existed to assure that the number and type trained were consistent with national needs.

We contacted 83 medical organizations and two osteopathic organizations and interviewed 225 graduate medical training program directors throughout the United States for their opinions on questions dealing with the (1) number and types of physicians needed, (2) amount of control, if any, considered necessary to achieve an appropriate mix of physician specialists, and (3) manner in which any change considered necessary could be achieved. A summary of the types of organizations contacted and those that replied is presented on page 8.

In addition, we reviewed literature dealing with the physician specialty distribution issue and ascertained what was being done by Federal, State, and local agencies.

Although two osteopathic organizations were contacted, we did not consider the impact of doctors of osteopathy on the issues discussed in this report because they constitute a very small percentage of all physicians in the Nation--less then 4 percent--and are heavily concentrated in a few States.

Organizations and Individuals Contacted During GAO Review

	Number contacted	Number responding
Medical organizations:		
--CCME, LCGME and its constituent organizations	7	7
--Residency review committees	23	23
--Specialty boards	22	20
--Specialty societies	20	19
--Subspecialty societies	11	10
Subtotal	83	79
Osteopathic organizations	2	1
Directors of graduate medical training programs	225	

CHAPTER 2

THE ADEQUACY OF SUPPLY OF PHYSICIANS IS UNKNOWN

The Congress and medical profession are concerned about whether the number of physicians practicing in various medical specialties is appropriate and whether a proper distribution of physicians by specialty is available in the United States to provide appropriate and quality medical care to persons needing it. Specifically, discussion has focused on whether enough physicians will be practicing in primary care specialties and whether too many physicians are or will be practicing in other specialties. In addition considerable debate has occurred on whether there is a sufficient aggregate supply of physicians in the Nation.

As discussed below, opinions we obtained from the medical profession tend to support the contention that more primary care physicians are needed but not the belief that there are too many specialists. In fact, none of the organizations we contacted expressed the opinion that their specialty was in oversupply. In addition, while no doubt exists that the aggregate number of practicing physicians in the United States has increased dramatically during the past decade and will continue to increase rapidly in the future, debate continues over whether the supply is adequate to meet national needs. Until decisions on the aggregate number of each type of specialist and subspecialist needed are made, it is unlikely that any accurate determinations can be made on the sufficiency of the aggregate supply of physicians in the Nation.

SUPPLY OF PRIMARY CARE PHYSICIANS

There appears to be some agreement in the medical profession that a shortage of primary care physicians exists in the United States. As discussed on page 12, this belief is not based on any particular study but rather on observations of personnel in the health care field. There appears to be some question, however, on the number of primary care physicians and physician extenders needed and the extent to which specialists and subspecialists should be relied upon to provide primary care.

What is a primary care physician and which types of physicians provide primary care?

CCME, in a January 1975 report, defined a primary care physician as one who establishes a relationship with an individual or a family and provides continuing surveillance of their health care needs, comprehensive care for the acute and chronic disorders for which he is qualified to care, and access to the health care delivery system for those disorders requiring the services of other specialists.

In January 1975, CCME took the position that the types of physicians which met the primary care definition included general and family practitioners, general internists, and general pediatricians. At that time, CCME excluded obstetricians/gynecologists as primary care physicians. In June 1976, however, CCME approved their inclusion as one of the primary care specialties.

As discussed on page 17, the Health Professions Educational Assistance Act of 1976 required, as a condition for receipt of capitation assistance, that 50 percent of first year graduate medical education training positions be filled by physicians engaged in primary care by fiscal year 1980. The act defined primary care physicians as including only those in family medicine, general internal medicine, or general pediatrics.

Certain other specialists, such as dermatologists and general surgeons, may also provide a considerable amount of primary care. According to the CCME, however, they are not identified either by education or practice as consistently fulfilling all the requirements of primary care physicians and therefore are not recognized by the CCME and its constituent organizations as primary care physicians.

In addition, many internists and pediatricians extend their graduate medical training into subspecialty fields and are consequently prepared to function principally as specialists rather than primary care physicians.

While graduate medical education is designed to prepare medical graduates to enter a specialty, it does not insure that individuals who complete such training will necessarily function in that specialty throughout their careers. Most physicians practice in the specialty in which they receive their graduate medical education. Many of these, however, may also provide considerable primary care to their patients. Also, the medical profession generally recognizes that some physicians, prepared by education as primary care physicians, eventually find their practice channeled into selected areas so that they eventually function as specialists. Although we are not aware of any completed studies that would provide data on how much this occurs, a study underway at the University of Southern California is focusing on this issue.

Who believes more primary care physicians are needed?

A number of medical organizations, the Congress, and the Administration generally agree that more primary care physicians are needed.

In June 1973, the House of Delegates of AMA recommended that the need for more primary care physicians should be accepted as fact even though it was difficult to determine precisely the additional number needed at that time. At the same time, the House of Delegates adopted a formal resolution that at least 50 percent of the medical school graduates should enter graduate medical training in primary care specialties in the coming years. In the same year, the Graduate Medical Education Committee of the AAMC recommended that 50 percent of graduating medical students enter training programs in the primary care specialties. In January 1975 CCME recommended an initial national target of having 50 percent of graduating medical students choose careers as primary care specialists.

We were advised by the AAMC that its 1973 goal appeared reasonable at that time. However, AAMC suggested that the adequacy of this estimate of need should be reexamined periodically. An official of one of the other medical organizations pointed out that the quoted figure that 50 percent of the graduate medical education training positions should be in primary care was derived by one individual as a number that sounded correct and easy to deal with; and it was not, by this individual's own admission, developed using any scientific basis.

We contacted 83 medical organizations and two osteopathic organizations. We asked them a number of questions, including whether they believed more primary care physicians were needed in the United States. Eighty replies were received from 79 medical organizations and 1 osteopathic organization.

Of 79 medical organizations responding,

--24 believed that more primary care physicians are needed,

--3 said no more are needed,

--17 said data was not available to answer the question,

--15 expressed no opinion, and

--20 did not specifically respond to the question.

The osteopathic organization said it believed that more primary care physicians are needed.

The medical organizations expressing the view that more primary care physicians are needed did not elaborate on their reasons for this position. Those which contend that additional primary care physicians are not needed in the United States generally point out that over the last few years enough physicians have been entering graduate primary care training programs and that possibly the mix has already moved too far toward producing primary care physicians.

Although the medical profession has not undertaken any broad based national studies in an effort to determine the approximate number and types of primary care physicians needed, the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists are currently engaged in major manpower studies for their respective specialties. In addition, a study of internal medicine manpower supported by the American Board and the American Society of Internal Medicine, the American College of Physicians and Association of Professors of Medicine is in progress. One objective of this study is to provide baseline data on manpower needs in internal medicine which can be used to develop rational guidelines for future training of internists.

The American Academy of Family Physicians has proposed that a manpower study be undertaken for their respective specialty. They advised us, however, that the problems of insufficient funding and personnel have been and continue to to be major roadblocks to the conduct of a study by the Academy to determine the needs of family physicians in the Nation.

Why is it believed that more primary care physicians are needed?

The belief that more primary care physicians are needed is not based on any particular study but rather on observations of personnel in the health care field that

--a primary care physician can take care of up to 85 percent of the problems for which people seek care;

--there has been a steady and continual decline in the percentage of practicing physicians engaged in primary care;

--there is probably an adequate number, or even an excessive number, of physicians engaged in the delivery of secondary or tertiary care; and

--the proportion of physicians now engaged in graduate medical education and the nature of that education are such that the percentage of physicians engaged in primary care is likely to decrease.

Other factors on which this position is apparently based include

--comparisons with the number of practicing primary care physicians in other countries, notably the United Kingdom, where more than 75 percent of all physicians are in primary care; and

--the number of primary care physicians used by a large health maintenance organization in the United States--about 70 percent of the staff.

In commenting on the draft report, CMSS advised us that several of its member organizations raised questions with the position that a primary care physician can take care of up to 85 percent of the problems for which people seek care. CMSS also advised us that strong sentiment was expressed by its member organizations concerning the need to better define what constitutes primary care and for a comprehensive study by the specialties of both manpower and health care needs.

AMA pointed out that the comparison of the percentage of primary care physicians used by a large health maintenance organization cannot be equated with national needs since there is wide variation on the proportion of specialists functioning in large group practices.

Has the percentage of MDs in primary care changed?

After World War II, the enormous growth of medical knowledge, stimulated by substantial and increasing financial support for biomedical research through the National Institutes of Health, according to several medical organizations, resulted in a growing movement toward specialization and subspecialization in medicine. Particularly as a result of this, the percentage of MDs in primary care in the United States declined from over 88 percent in 1931 to 42 percent in 1976. (See p. 15.)

To what extent has change occurred in the number of physicians engaged in primary care training programs?

Although the total number of physicians in graduate medical education training programs increased from about 17,500 to 39,000 between 1950 and 1970, the percentage of those in primary care training continually declined (from 36 to 33 percent) during this period.

Changes have occurred in graduate medical education in recent years, particularly in family practice since it was approved as a medical specialty in 1969. That action should eventually affect the number of practicing physicians engaged in primary care.

In an attempt to reverse the physician trend toward specialization and away from primary care, the Comprehensive Health Manpower Training Act of 1971 authorized, for the first time, special project grants to establish and operate approved graduate medical education training in family practice. HEW provides these grants directly to the educational institution, and they may be used for any purpose in supporting graduate family practice training, including stipends for physicians enrolled in such programs. HEW obligated over $92.2 million to support graduate family practice training during fiscal years 1972-77. HEW is supporting 210 family practice training programs in fiscal year 1978. HEW estimates that during fiscal year 1978 these programs include 72 percent of all family practice residents in training.

As a result of formal recognition of family practice, Federal and State funding for primary care training programs, and increased interest by medical school graduates in primary care graduate training programs, the percentage of physicians engaged in primary care training increased from 34 percent in school year 1971-72 to 48.6 percent in school year 1976-77, with the largest percentage increase occurring in family practice. (See p. 16.)

Primary care specialties in the 1976-77 school year accounted for a greater percentage of filled graduate medical training positions than at any time in the last 27 years.

Filled Graduate Medical Education Training Positions in Affiliated and Nonaffiliated Hospitals
School Years 1971-72 to 1976-77 (note a)

Type of physician	1971-72		1972-73		1973-74		1974-75		1976-77	
	Number	Percent of total	Number	Percent of total	Number	Percent of total	Number	Percent of total	Number	Percent of total
Primary care:										
General/Family Practice	878	2	1,312	3	2,025	4	2,955	6	5,015	8.3
Internal medicine (note b)	7,869	18	8,297	18	9,427	19	11,024	21	15,367	25.5
Obstetrics/ Gynecology	2.800	7	3,006	7	3,183	7	3,421	6	3,899	6.5
Pediatrics	2,844	7	3,238	7	4,231	9	4,784	9	5,028	8.3
Total primary care	14,391	34	15,853	35	18,866	39	22,184	42	29,309	48.6
Surgical specialties	13,570	32	13,799	31	14,299	29	14,738	28	15,118	25.1
Other specialties	14,332	34	15,206	34	15,704	32	15,577	30	15,891	26.3
Total filled positions	42.293	100	44,858	100	48,869	100	52,499	100	60,318	100.0

a/1975-76 figures are not available according to an AMA representative.

b/Many of these physicians extend their graduate medical training into subspecialty fields and subsequently may function as specialists rather than primary care physicians.

Source: American Medical Association

The number of physicians in primary care training should continue to increase in the future because increasing numbers of medical students are listing primary care as their first choice in selecting a specialty.

An April 1976 report of the National Intern and Resident Matching Program showed that during the years 1974-76, the number of available graduate training positions in primary care specialties had increased, an increasing number of U.S. medical students were applying for these positions, and the number selected for primary care positions had increased.

Furthermore, statistics on filled graduate training positions at the 16 medical schools visited show that the number in primary care training increased between school years 1973-74 and school years 1975-76.

In commenting on the report, the American Academy of Family Physicians (AAFP) stated that emphasis is on the first-year graduate (residency) positions needed to provide more physicians in primary care, with the inference that a comparable number of physicians will remain in the field of primary care at the end of graduate medical training. AAFP believes this is a false measurement and of equal, if not greater importance, is a study of the outcome data. According to AAFP, although hard data for all specialties involved are not currently available, convincing evidence exists that a much higher percentage of first-year family practice residents enter primary care than those in other specialties.

Establishment of congressional goals for graduate training positions in primary care

The Health Professions Educational Assistance Act of 1976 (Public Law 94-484) requires, as a condition for receipt of a grant, that 50 percent of first-year graduate medical education training positions be filled by physicians engaged in primary care specialties of family medicine, general internal medicine, or general pediatrics by fiscal year 1980.

To receive capitation support 1/ after fiscal year 1977, medical schools must have specified percentages of filled first-year graduate training positions in direct or affiliated primary care training programs. The required percentage of

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1/Capitation grants provide a specified number of dollars to a school for each full-time enrolled student.

filled first-year primary care training positions in family medicine, general internal medicine, or general pediatrics are:

--35 percent for fiscal year 1978 grants.

--40 percent for fiscal year 1979 grants.

--50 percent for fiscal year 1980 grants.

If these percentage requirements are not met by a national average of all schools, then each medical school must meet the percentage requirements for its programs to continue to receive capitation grants.

When a school is required to have a specified percentage in primary care positions, the Secretary of HEW may determine that the requirement has been met if he determines that a school has made good faith efforts to meet the requirement and has at least 98 percent of the required percentage.

The number of filled first-year graduate medical training positions in the primary care specialties of family practice, general internal medicine, and general pediatrics increased from about 32 percent of the total in school year 1971-72 to approximately 47 percent in school year 1976-77, the latest period for which data was available. (See p. 19.)

However, as reported in 1973 by AMA, even if the number of physicians entering primary care training totals 50 percent for the next decade, the total number of primary care specialties in practice, exclusive of obstetrics and gynecology, would increase only from 35.1 percent to 38.6.

Significant growth in physician extender programs

In recent years a new health profession has been developed to increase physician productivity and help relieve problems of geographical and specialty maldistribution of health care personnel. Assistants to the primary care physician--physician extenders--can perform many medical tasks that do not require the extensive knowledge and skill of a physician, freeing physicians for more complex cases and increased patient loads. Graduates of these training programs are referred to by various names. They can, however, be categorized into two groups: physician assistants and nurse practitioners.

First-Year Filled Graduate Medical Education Positions for School Years 1971-72 to 1976-77 (note a)

	1971-72		1972-73		1973-74		1974-75		1976-77	
	Number	Percent of total	Number	Percent of total	Number	Percent of total	Number	Percent of total	Number	Percent of total
Primary care:										
General/Family practice	447	2.9	660	3.9	942	5.2	1,361	7.2	2,024	10.2
General internal medicine	3,166	20.9	3,556	21.2	4,139	22.9	4,553	24.2	5,522	27.8
General pediatrics	1,262	8.3	1,466	8.8	1,699	9.4	1,810	9.6	1,886	9.5
Total primary care	4,875	32.1	5,682	33.9	6,780	37.5	7,724	41.0	9,432	47.5
Surgical specialties (note b)	5,235	34.5	5,659	33.7	5,846	32.3	5,852	31.1	5,653	28.5
Other specialties	5,071	33.4	5,432	32.4	5,450	30.2	5,240	27.9	4,746	23.9
Total	15,181	100.0	16,773	100.0	18,076	100.0	18,816	100.0	19,831	100.0

a/1975-76 figures are not available according to an AMA representative.

b/Includes obstetrics gynecology positions of 811, 1,323, 1,003, 1,330, and 1,065 for school years 1971-72 through 1976-77, respectively.

Source: American Medical Association.

Some university-initiated programs began as early as 1965. Direct HEW support, however, did not begin until 1969 as a demonstration project to train former military corpsmen for this role. Subsequently, the Comprehensive Health Manpower Training Act of 1971 (Public Law 92-157) and the Nurse Training Act of 1971 (Public Law 92-158) authorized HEW to support a variety of physician extender programs which were designed to improve the health services delivery system and the distribution, supply, quality, use, and efficiency of health personnel.

HEW has funded about 100 different training programs for physician extenders through grants to universities and other nonprofit organizations. HEW support from 1969 to 1977 totaled about $64 million. HEW data for the last three fiscal years is shown below.

	Fiscal year 1975		Fiscal year 1976		Fiscal year 1977	
Program	Number of programs	Amount obligated	Number of programs	Amount obligated	Number of programs	Amount obligated
Physician assistants	37	$ 5,994,002	36	$6,247,203	39	$8,414,808
Nurse practitioners	46	5,307,225	a/49	2,972,436	57	1,876,110
Total	83	$11,301,227	85	$9,219,639	96	$10,290,918

a/Some of these programs are multiyear contracts. The funds were obligated in preceding years.

HEW officials estimated that about 5,000 students have graduated from federally supported training programs. The trend in the number of graduates has increased dramatically. In fiscal year 1976 alone, more than 1,700 students graduated from physician extender training programs.

HEW officials informed us that they have very little information on the employment status of physician extenders. Placement of graduates, for the most part, has been left to the discretion of the individual programs. Current studies are attempting to identify, at least in part, the employment status of the physician extender.

A June 1977 HEW report of the physician extender work group stated that demand for physician extenders is not well understood, is subject to a number of forces, and future demand questions remain largely unanswered. Therefore, no answer exists at present as to the optimum number of physician extenders the market can absorb. Because of the increased (1) emphasis on primary care, (2) number of physicians entering primary care practice, and (3) number of physician extenders graduating from HEW-supported training programs, a need exists to determine the demand for physician extenders and the number that can be absorbed by the health care system.

AMA stated, in responding to the draft report, that the question is not the optimum number of physician extenders the market can absorb but rather how physicians can be educated to the advantages of employing physician extenders. AMA stated that the demand for and use of physician extenders may decline as the number of physicians greatly increases.

CONCLUSIONS

There appears to be general agreement on the need to train more primary care physicians in the United States. There appears to be some question, however, on (1) the number of primary care physicians needed, (2) the number of physician extenders needed and their overall impact on the number of primary care physicians, and (3) the extent to which specialists and subspecialists should be relied on to provide primary care.

Statements indicating that more primary care physicians are needed are based largely on (1) statistics showing a steady decline in the percentage of practicing physicians engaged in primary care, (2) comparisons with the number of practicing primary care physicians in other countries, and (3) the observation that a primary care physician can take care of the vast majority of problems for which people seek care.

As a result of a growing movement toward specialization and subspecialization in medicine since World War II, the percentage of M.D.s in primary care declined from over 88 percent in 1931 to 42 percent in 1976. However, initiatives to increase the number of graduate medical education positions in the primary care specialties provide cause for optimism in the future. Attaining the goals established by both the Federal Government and medical professional organizations to train more primary care physicians should affect the number of practicing primary care physicians in the future. Furthermore, appropriate use of the increasing number of physician extenders should enable the primary care physician to provide services to more patients.

SUPPLY OF OTHER SPECIALISTS

While considerable agreement exists on the need for additional primary care physicians, opinions differ regarding what constitutes a sufficient supply of other specialties and whether too many of certain types of physician specialists are being trained. Specifically, some studies have suggested that certain specialties, notably surgery, neurosurgery, urology, and cardiology may now be training too many specialists.

However, none of the specialty boards, specialty societies, and residency review committees expressed the opinion that an excess supply of physicians existed within their specialty. Rather, the majority of those expressing an opinion believe that the supply within their individual specialty is inadequate. Yet, only half these organizations were in a position to provide us with an estimate on an appropriate physician to population ratio for their specialty which could provide the basis for estimating the approximate number of additional physicians needed for their specialty. The rest expressed no opinion on what ratio of physician to population would be appropriate for their specialty.

Types of physician specialists and subspecialists

Before 1970 AMA recognized 34 different specialties in its directory listings. In 1970 it revised its format to include an array of 63 specialties and subspecialties. In recent years, more specialties have come into being. The table on page 23 shows 69 physician specialties and subspecialties in the AMA Directory of Approved Residencies for school year 1974-75.

Studies on the sufficiency of supply of specialists and subspecialists

The medical profession has not undertaken any comprehensive national studies designed to determine the appropriate number and type of physician specialists and subspecialists needed. However, studies have been undertaken by several medical organizations to obtain information on the sufficiency of supply within their particular specialties. Several additional medical organizations either are planning or are conducting studies in their respective specialty.

In considering the supply of physician manpower in a particular specialty or subspecialty, AMA has pointed out that specialties are interdependent, and the need for one type of physician is affected by the supply of others.

Table of Approved Residencies for School Year 1974-75

Specialties

Primary care:

- Family practice
- Internal medicine
- Obstetrics/Gynecology
- Pediatrics

Surgical:

- Surgery
- Colon and rectal surgery
- Neurological surgery
- Ophthalmology
- Orthopaedic surgery
- Otolaryngology
- Plastic surgery
- Thoracic surgery
- Urology

Other:

- Anesthesiology
- Dermatology
- Nuclear medicine
- Pathology
- Physical medicine and rehabilitation
- Preventive medicine
- Psychiatry and neurology
- Radiology

Subspecialties

Internal medicine:

- Allergy and immunology
- Cardiovascular disease
- Endocrinology and metabolism
- Gastroenterology
- Hematology
- Infectious disease
- Medical oncology
- Nephrology
- Pulmonary disease
- Rheumatology

Pediatrics:

- Pediatric allergy
- Pediatric cardiology

Obstetrics/Gynecology:

- Gynecology
- Obstetrics

Pathology:

- Anatomic pathology
- Anatomic pathology and medical microbiology
- Anatomic pathology and clinical pathology
- Anatomic pathology and neuropathology
- Chemical pathology
- Medical microbiology
- Medical microbiology and medical chemistry
- Clinical pathology
- Forensic pathology
- Hematology
- Clinical pathology/hematology
- Neuropathology
- Anatomical, clinical, and forensic pathology
- Blood banking

Preventive medicine:

- General preventive medicine
- Aerospace medicine
- Occupational medicine
- Public health

Psychiatry and neurology:

- Neurology
- Child neurology
- Psychiatry
- Child psychiatry

Radiology:

- Diagnostic roentgenology
- Diagnostic radiology
- Medical nuclear physics
- Radiological physics
- Radium therapy
- Roentgen ray and gamma ray physics
- Roentgenology
- Therapeutic radiology
- Therapeutic roentgenology
- Therapeutic radiological physics
- Therapeutic and diagnostic radiological physics

Otolaryngology:

- Endoscopy

Therefore, increases in the number of surgeons may result in a need for more pathologists, anesthesiologists, or radiologists. On the other hand, when a general surgeon functions as the urologist, gynecologist, or family practitioner in a given geographic area, the need for these particular specialists may be reduced.

AMA has taken the position that the nature of each physician's practice will be determined in part by the number and different types of practicing physicians. Consequently, it believes it is inappropriate to determine the total regional or national need for numbers and types of physicians by determining separately the need for each type of specialist as perceived by the members of that specialty.

AMA recognizes that some major specialty societies have estimated the number of specialists needed in some fields. But, according to AMA, the sum of these parts is probably much greater than the total need because the presence of the full supply of any one of the specialties would almost certainly reduce the needs in overlapping specialties.

We identified 14 studies made by medical specialty organizations over the last few years which attempted to obtain information on the sufficiency of supply within their particular specialty or subspecialty. A study on surgery stated that the number of physicians entering and completing training each year is larger than that required by population needs. Also, four of the studies (orthopedic surgery, cardiology, neurosurgery, and urology) concluded or implied that an oversupply of practicing physicians would occur if the present trend in the number engaged in graduate training programs continues. All but one of the five studies (orthopedic surgery) recommended reductions be made in the number of physicians being trained in their respective specialties.

Six of the 14 studies (otolaryngology, anesthesiology, preventive medicine, pulmonary disease, neurology, and physical medicine) concluded that there was an undersupply of physicians in practice in those specialties and subspecialties, although three studies (thoracic surgery, pathology, and radiology) concluded that an adequate supply of physicians existed in practice in those specialties.

Following are some details from the reports on surgery, neurosurgery, and urology manpower studies recommending or implying that action should be taken to reduce the number of physicians being trained. It should be recognized that, under the present graduate medical education process, implementing recommendations made by specialty and subspecialty organizations to adjust the number of physicians trained in a particular specialty or subspecialty would in almost all cases be voluntary by the training institutions and the several hundred individual directors of graduate training programs located throughout the United States, as discussed in the next two chapters of this report.

Study of surgical services for the United States

This study, sponsored jointly by the American College of Surgeons and the American Surgical Association, with financial assistance from HEW, was directed toward evaluating the distribution of surgical services, the problems of manpower, and the interaction of surgery with other fields of medicine. The summary report, issued in 1975, concluded, among other things, that the number of physicians now entering and completing graduate training in surgical specialties each year is larger than required by population needs, and that a conservative manpower goal would involve reducing the number of physicians in graduate surgical training.

In commenting on our draft report the American College of Surgeons (ACS) stated that (1) although this study was funded by their organization and a number of other private and Government organizations, ACS provided less than 10 percent of the total funding of about $1.5 million, (2) the individuals conducting the study worked as independent scholarly researchers, and (3) none of their findings and recommendations have been officially endorsed by the ACS, or adopted as official position or policy.

Neurosurgery manpower study

This study, conducted by the American Association of Neurological Surgeons, under contract with HEW, was directed to provide information on the number of neurosurgeons, their pattern of distribution, and the current practice of neurosurgery. Their report, issued in February 1975, proposed an initial reduction of 25 percent in the number of physicians entering neurosurgical training with a subsequent decrease of 10 to 20 percent in 5 years, if necessary.

Urology manpower and training program survey

This survey, sponsored by the American Urological Association, Inc., was directed toward obtaining nationwide information on urologic manpower and urologic training programs, as well as an appropriate urologist to population ratio. The survey report, issued in May 1976, noted that by 1985, a significant overproduction of urologists would occur if the present trend in the number of physicians involved in graduate training continues at present rates. Accordingly, the survey recommended an immediate decrease of about 10 to 20 percent of those physicians in urology training.

HEW studies

HEW has also conducted studies on physician manpower. For example, in 1975 HEW prepared a draft report 1/ of a study it conducted on physician specialty distribution. The objectives were to (1) present a picture of specialty distribution as it appeared at that time and as it may appear through the decade, (2) identify specific areas that need to be addressed by Federal policy, and (3) given certain options to recommend a current course of action. The HEW study concluded that uncertainty exists surrounding physician supply and requirements by specialty and that, in the future, more information and understanding of the issues will be necessary before fine adjustments in the distribution of physician manpower resources can take place with confidence.

As part of this study, HEW calculated what the physician to population ratio would likely be in 1980 for most specialties and also developed an estimate of physician to population ratios needed in 1980 to meet the needs of the U.S. population. HEW advised us that these projections for 1980 and conclusions drawn relating to over- and under-supplied specialists were based on assumptions concerning the existence of archetypal comprehensive health insurance and were couched in conditional statements concerning, for example, the geographic distribution, the substitution of nonphysician health manpower, and the influx of foreign medical graduates. Based on its analysis,

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1/An HEW official said this report was never finalized. HEW, however, is preparing a series of new reports on the subject in connection with its Graduate Medical Education National Advisory Committee, which is discussed on p. 65.

while recognizing the tenuous nature of the data, HEW projected the following specialties to be in undersupply and oversupply in 1980:

HEW Projections of Specialties in Undersupply and Oversupply

Undersupply:	Oversupply:
Family practice	Pediatrics
Internal medicine	Surgery
Obstetrics/Gynecology	Neurological surgery
Otolaryngology	Orthopedic surgery
Plastic surgery	Thoracic surgery
Urology	Neurology
Opthalmology	Pathology
Anesthesiology	Radiology
Dermatology	
Physical medicine and rehabilitation	

Opinions of medical organizations regarding the sufficiency of supply of specialists

We contacted a number of medical organizations responsible for accrediting graduate medical training programs and for certifying specialists and representing their professional interests and two osteopathic organizations. A series of questions were asked of these organizations regarding the sufficiency of physician supply within the various specialties.

Of 79 medical organizations responding:

--Six expressed the opinion that in general fewer nonprimary care specialists were needed.

--One said more nonprimary care specialists are needed.

--The majority (72) either expressed no opinion or did not specifically respond to the question.

One osteopathic organization responded with the belief that fewer nonprimary care physicians are needed. None of these organizations gave explanations for their positions.

To obtain opinions on the sufficiency of supply within each of the major specialties, we contacted the residency review committee (accrediting body), specialty board (certifying body), and specialty society (spokesperson organization for practicing specialists) for each of the 23 medical specialties and asked questions on the sufficiency of supply within their respective specialty in addition to the above questions.

None of the 65 1/ organizations contacted believed that an oversupply of physicians existed within its specialty. (See p. 29.) Rather:

--One organization representing radiologists believed that the supply of diagnostic radiologists was adequate, but therapeutic radiologists were in undersupply;

--One organization representing ophthalmologists and otolaryngologists believed there was an undersupply of otolaryngologists but expressed no opinion on the supply of ophthalmologists;

--24 other organizations believed that ther · was an undersupply of physicians within their respective specialty;

--Five others believed the supply was adequate;

--12 said they did not have the data necessary to answer the question;

--19 expressed no opinion on the sufficiency of supply within their specialty, and

--Three organizations did not respond.

Studies cited by 17 medical organizations apparently formed the basis for the position that their specialties were in under or adequate supply. Ten of the 24 organizations which expressed the view that their specialty was in undersupply, apparently did so based on professional judgment or opinion rather than any manpower studies. Several of these apparently based their opinions on such factors as the demands of medical school graduates desiring training in a particular specialty and unfilled requests for particular specialists by communities and academic institutions.

1/Two organizations representing urologists had different views on the sufficiency of supply within that specialty. One believed there was an undersupply although the other believed the supply was adequate. This was the only inconsistency noted.

We asked the above organizations to provide us with a physician to population ratio for their specialty which they would consider adequate to meet the health care needs of the Nation. Less than half the organizations which believed that their specialty was in undersupply could give us such an estimate. (See app. II.)

The following schedule shows (1) optimal physician to population ratios as expressed by certain medical organizations, (2) the estimated 1980 physician to population ratio for those specialties developed by HEW, and (3) the actual ratio of these specialists to population on December 31, 1976--the latest date for which data was available.

Optimal Physician to Population Ratios as Estimated by

Specialty	Specialty society	Specialty board	Residency review committee	HEW estimates for 1980	Actual Ratio in December 1976 (notes c and d)
Colon and rectal surgery	1:100,000	1:100,000	(a)	(a)	1:120,100
Family practice	1: 2,500	(b)	1: 2,500	(a)	1: 1,900
Neurology	1: 25,000	(a)	(a)	1: 55,600	1: 48,700
Obstetrics/ Gynecology	1: 10,000	(a)	(a)	1: 7,500	1: 9,700
Physical medicine	1: 50,000	(a)	(a)	1: 77,000	1:125,600
Thoracic surgery	1:100,000	1:100,000	(a)	1: 91,000	1:105,800
Plastic surgery	(b)	1: 50,000	1: 50,000	1: 45,569	1: 91,800
Otolaryngology	(a)	1: 33,000	(a)	1: 22,700	1: 16,700
Dermatology	3.2:100,000	1: 30,000	(a)	1: 35,700	1: 44,700
Urology	1.67-4:100,000	1: 30,000	(a)	1: 27,000	1: 31,200

a/Not given.

b/No reply.

c/Based on resident U.S. population data.

d/Population ratios are rounded to the nearest hundred.

As can be seen above, many specialties had not reached the optimal ratio their organizations believe would be adequate to meet national needs. However, in some cases (obstetrics/gynecology, thoracic surgery, and urology), the number in December 1976 was close to or exceeded the optimal ratio considered adequate by the specialty organization.

We also contacted 11 organizations representing subspecialties of internal medicine and asked their opinion on the sufficiency of supply within their respective subspecialty. Of the 10 organizations responding,

--3 believed that there was an undersupply of physicians in their specialties (hematology, rheumatology, and allergy);

--for gastroenterology, 1 subspecialty organization believed its subspecialty was in undersupply, although the other subspecialty organization stated it did not know if there was an under, over, or adequate supply;

--1 organization believed the supply was adequate within its specialty (pulmonary disease); and

--4 organizations either expressed no opinion or did not respond to the question.

The medical organizations which believed that their subspecialties were in under or adequate supply did not identify the rationale for their positions.

Possible consequences of an excess supply of specialists

Some directors of graduate medical training programs are concerned that severe consequences may result from training too many specialists relative to the need for their services. Since most physicians' income depends on the number of medical procedures performed (operations, therapeutic and diagnostic procedures, office visits) and since they are usually the only person judging the necessity for the procedure, they fear that overcrowding may cause some specialists to provide unnecessary services.

Another possible consequence cited by program directors is that some surgeons may begin providing primary care for which they are technically qualified but not adequately trained. This causes a waste of training dollars because highly trained specialists, such as neurosurgeons, are not using the skills they acquired during a 5-year graduate medical training program.

Finally, other program directors said dilution of a specialist's skill is a serious consequence of having excessive practitioners. Increasing numbers of specialists will have fewer and fewer opportunities to practice and maintain their skill on a constant number of patients requiring their services.

In summary, as the President of the American Association of Neurological Surgeons wrote in 1972:

> "* * * An excess of any specialty will result in a poorer type of delivery of health services.

> There will be further fragmentation and dilution of clinical material, in addition to the performance of unnecessary diagnostic and therapeutic procedures. * * *"

In commenting on the draft report the American College of Surgeons pointed out that increases in the number of primary care physicians could also result in an excessive amount of outpatient services.

CONCLUSIONS

Studies have been made suggesting that some specialties may now be training too many specialists. Yet, none of the medical organizations we contacted believe that there are too many physicians within their specialties. Many, however, based their opinions on professional experience or judgment, not on any scientific studies designed to provide the data necessary to make such determinations.

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In responding to our draft report, AMA stated that factual information should be available to justify opinions that a specialty is either in adequate or inadequate supply and without such information, the views expressed are open to question. AMA also stated that if the specialties were requestioned on the adequacy of their number in 1977, there would undoubtedly be some specialties such as neurosurgery, which would now report oversupply. AMA mentioned that most specialty societies are currently engaged in studies of the adequacy of the numbers of physicians in those specialties, and it is hoped that this data will be available within a reasonable time.

AGGREGATE SUPPLY OF PHYSICIANS IN THE NATION

Considerable debate has occurred in the last 20 years on whether there is a sufficient aggregate supply of physicians in the Nation. This issue has not been resolved.

Over the past 20 years, a number of Presidential and other commissions have examined health care and concluded that the number of physicians should be substantially in creased. Study estimates of present and future needs for physicians and the criteria used--attainment of a given physician to population ratio--are shown on page 33. It should be noted that the physician to population ratio used for estimating need varied with the group performing the study.

Summary of Studies Made on the Future Physician Needs in the United States

Date of publication	Reporting body	Estimated shortage or future need for physicians	Standard used for estimated need
1953	President's Commission on the Health Needs of the Nation	For 1960, U.S. needs: 7,000 more	To maintain the 1940 physician-population ratio of 133 per 100,000.
		11,000 more	To maintain the 1949 physician-population ratio of 135 per 100,000.
		24,000 more	To maintain the 1949 ratio and also meet projected military needs.
		43,000 more	To have one private physician per 1,000 civilian population and maintain 1949 levels in hospitals, schools, and military.
		35,000 more	To bring all geographical areas with low physician-population ratios up to the national average.
		62,000 more	To bring all geographical areas up to a ratio of 166 physicians per 100,000 population. All estimates based on projected 1960 population of [illegible],176,000.
1959	Surgeon General's Consultant Group on Medical Education (The Bane Committee)	Need to graduate 3,600 more per annum.	To maintain the 1959 physician-population ratio of 141 per 100,000 through 1975. Estimated 1975 population--235,246,000.
1965	President's Commission on Heart Disease, Cancer, and Stroke	Existing shortage of 20,000 physicians. Need to graduate 2,000 more per annum and increase to 1,300 more by 1975 to raise total by 57,000.	Based on standard of one private physician per 1,000 civilian population. To maintain the 1965 physician-population ratio of 149 per 100,000. Based on estimated 1975 population of 210,000,000.
1967	Task Force on Health Manpower	Existing shortage of 35,000 physicians. Need for 58,000 more by 1975.	To bring every low state's physician-population ratio up to the national average. To maintain the 1965 physician-population ratio of 153 per 100,000. Based on estimated 1975 population of 232,221,000.
1967	U.S. Public Health Services	Existing shortage of 53,000 physicians in 1966. Need for 103,000 more by 1975	Based on standards of 100 physicians exclusive of hospital staff per 100,000 population, which is average ratio of prepaid group practice plans.
1967	National Advisory Commission on Health Manpower	Shortage exists because physician productivity is not keeping pace with demand for services. Future needs will depend on improvements in health-care system and physician productivity.	No numerical standard given for number of physicians in population.
1970	Carnegie Commission on Higher Education	Existing shortage of 50,000. Increase medical school entrants by 52% by 1976.	To achieve physician-population ratios of 161.4 per 100,000 by 1977 and 216.4 per 100,000 by 2002.

SOURCE: Journal of the American Medical Association, Oct. 9, 1972, Vol. 222 No. 2.

Those who continue to believe that a physician shortage exists cite as further evidence continual demands for admissions to medical schools and the sustained influx of foreign-trained physicians into the United States to fulfill the Nation's medical needs.

AMA believes that a shortage exists and that both short- and long-range solutions are needed to alleviate it. In a July 1975 paper prepared for members of the Congress, AMA stated that the best short-range way to obtain more physicians is to expand medical schools enrollments, and the best longer range solution is to establish new medical schools.

In November 1975 the Secretary of HEW stated that adequate numbers of health professionals will soon be in practice. The Secretary noted that in the past 4 years, medical school enrollment had increased by 34 percent and graduates by 45 percent, and that further increases in graduates will be forthcoming in the next few years. Instead of an overall shortage, the Secretary pointed to two more pressing problems--geographic and specialty maldistribution. He concluded that, without Federal efforts to alter institutional and individual incentives, correction of these imbalances is likely to occur slowly, if at all.

Those who believe that there are enough physicians conclude that, even if there were a shortage, this is probably a short-term problem calling for short-term solutions. They believe that alternatives to correct this short-term problem would include continuing the liberal policy toward the immigration of foreign-trained physicians and striving harder to increase physician productivity. Furthermore, they believe that building or expanding training facilities might result in long-range physician oversupply.

In this regard, a report issued by the Carnegie Council on Policy Studies in Higher Education in 1976 concluded that the U.S. shortage of physicians appears to have ended. Their report noted that in 1970 there was a reported shortage of 50,000 physicians, but at the end of 1975, the number of active physicians and osteopaths had increased by 55,000. Possibly as a result, the Carnegie Council warned that there is serious danger of developing too many new medical schools, and decisive steps need to be taken by both Federal and State Governments to stop this trend.

According to the Carnegie Council report, in addition to the 114 medical schools that were enrolling students at the time of their study, at least 13 additional schools were in various stages of development, some of which were being funded by VA, and many more were being proposed by various communities. The council believes most of these developing medical schools are not necessary and failure to impose stricter controls by combined Federal and State action over development of new medical schools could well contribute to an excessive increase in the aggregate supply of physicians.

How fast is the aggregate supply of physicians increasing?

In recent years, the number of active physicians has been growing faster than the population as a whole, and, therefore, the number of physicians to population has been increasing. The increase is due partly to the formation of new medical schools and an increase in the enrollments of existing medical schools, and partly to an appreciable increase in the number of foreign-trained physicians practicing in the United States. Simultaneously, there has been a decline in the rate of growth of the total U.S. population. HEW pointed out that while a decline in the growth rate for the total U.S. population is projected for the 1980s, recognition should be given to the anticipated sharp increase in the proportion and absolute number of individuals over 60 which, as a group, require more intensive medical care than people in other groups. It should also be recognized that the Health Professions Educational Assistance Act of 1976 will drastically restrict the number of foreign medical graduates practicing in the United States.

In 1950 there were about 233,000 physicians, or a ratio of 149 physicians per 100,000 population. The number of physicians has grown steadily since then and at the end of 1976, the latest period for which data is available, the number had increased to about 425,000 physicians, or a ratio of 197 physicians per 100,000 U.S. population.

Projections of future supply of physicians seem to indicate there will be over 200 physicians per 100,000 population before 1985. In congressional testimony in 1975, the then Secretary of HEW indicated that the physician to population ratio would rise to between 207 and 217 per 100,000 in 1985. He commented that these rates would place the United States near the top of all industrialized nations in terms of overall physician supply. These estimates assumed a 40-percent reduction in the inflow of foreign medical graduates because of increases in the number of U.S. graduates and the likely actions of both the private and public sectors in addressing the training of both foreign and domestically educated physicians.

Similar projections were made by the Carnegie Council on Policy Studies in Higher Education in its 1976 report. The council projects a physician to population ratio of 210 to 218 per 100,000 by 1985 and 221 to 232 per 100,000 by 1990. The Carnegie projections were also based on the assumption that the net inflow of foreign medical graduates would decline. A chart showing the steady increase in the aggregate supply of physicians in the United States is shown below.

Supply and Projections of Physicians in the United States for Selected Years

Year	Doctors of medicine	Doctors of osteopathy	Total	Ratio per 100,000 population
1950	219,997	12,700	232,697	149
1955	241,711	13,500	255,211	150
1960	260,484	14,349	274,833	148
1963	276,475	12,713	289,188	149
1964	284,224	12,865	297,089	151
1965	292,088	13,027	205,115	153
1966	300,375	13,184	313,559	156
1967	308,630	13,415	322,045	158
1968	317,032	13,700	330,732	161
1969	324,942	a/14,000	338,942	163
1970	334,028	a/14,000	348,328	166
1971	344,823	a/14,000	358,823	170
1972	356,534	a/14,000	370,534	173
1973	366,925	a/14,000	380,925	177
1974	379,748	14,929	394,629	182
1975	393,742	14,783	408,525	191
1976	409,446	15,436	424,882	197
1985	-	-	b/491,000-510,000 c/494,100-519,100	b/210-218 c/207-217
1990	-	-	-	b/221-232

a/Estimated.

b/Estimated by Carnegie Council.

c/Estimated by HEW.

Sources: National Center for Health Statistics, HEW, Progress and Problems in Medicine and Dental Education by Carnegie Council on Policy Studies in Higher Education; American Osteopatic Association; and American Medical Association.

Since enactment of the Health Professions Educational Assistance Act of 1963 (Public Law 88-129), the number of medical schools has increased from 87 in 1963 to 114 in school year 1975-76. First year enrollments have increased dramatically from 8,856 students in 1964 to 15,351 in school year 1975-76, a 73-percent increase. Equally significant is the increase in the number of medical school graduates which rose by about 84 percent, from about 7,300 graduates in 1964 to about 13,500 in 1976, as shown below.

American Medical School Enrollments and Graduates for the School Year Period 1964-76

School year	Number of schools	First year enrollment	Total enrollment	Graduates
1963-64	87	8,772	32,001	7,336
1964-65	88	8,856	32,428	7,409
1966-67	89	8,964	33,423	7,743
1968-69	99	9,863	35,833	8,059
1970-71	103	[illegible]	40,487	8,974
1971-72	108	[illegible],361	43,650	9,551
1972-73	112	13,726	47,546	10,391
1973-74	114	14,185	50,886	11,613
1974-75	114	14,963	54,074	12,714
1975-76	114	15,351	56,244	13,561

Source: American Medical Association and Division of Manpower Intelligence, HEW.

In passing the Health Professions Educational Assistance Act of 1976 (Public Law 94-484), the Congress declared that

> "* * * there is no longer an insufficient number of physicians and surgeons in the United States such that there is no further need for affording preference to alien physicians and surgeons in admission to the United States under the Immigration and Nationality Act."

CONCLUSIONS

Considerable debate continues over whether there is a sufficient aggregate supply of physicians in the United States. Studies of the past few decades relied on physician to population ratios for estimating needs and these varied with the group performing the study. Although some believe there are not enough physicians in the Nation, others believe we may be nearing a situation in which we will produce more physicians than we need.

In our opinion, a reasonably accurate determination can be made only after the number of specialists and subspecialists required to meet national needs has been determined.

CHAPTER 3

GRADUATE MEDICAL TRAINING PROGRAMS ESTABLISHED WITH LITTLE REGARD TO NATIONAL NEED

No system exists for insuring that the number and type of physicians trained is consistent with or related to the appropriate number needed. Rather, decisions on the type and size of graduate medical education training programs offered are

--usually made by individual medical school and hospital program directors in several hundred institutions located throughout the United States with little or no consideration to national needs;

--influenced by funds available, need to provide balanced training within a medical school, and patient care needs of training institutions; and

--not coordinated with identical training programs offered elsewhere to assure training of an appropriate number and type of physicians in the Nation.

Three Federal agencies--VA, DOD and HEW--either support directly or indirectly a significant number of graduate medical education training positions. Each Federal agency operates its own program to meet its objectives with little, if any, coordination between the Federal agencies or between those in the Government and in the private sector who operate identical graduate medical education training programs.

Although VA was given responsibility by the Congress for assisting in providing an adequate supply of health manpower to meet national needs and general agreement appears to exist on the need to train more primary care physicians, especially family practitioners, VA supported 11 family practitioner positions, or less than 1 percent of all its graduate medical training positions in fiscal year 1976. In addition, while many believe we may soon be training too many physicians, VA is involved in increasing the number of medical schools and the overall supply of physicians to comply with Public Law 92-541.

Graduate medical education training programs in the United States are designated as affiliated or nonaffiliated. Affiliated programs are those carried out in hospitals associated with a medical school for the purpose of providing graduate medical education. Nonaffiliated programs are carried out in a hospital under the chief of medicine or surgery. These hospitals select their program participants.

During the 1975-76 school year, a total of 65,357 graduate medical education positions were offered in the United States, including 24,974 first-year positions. 1/ About 59,000, or 90 percent, were in affiliated programs, and the remainder were in nonaffiliated programs.

Affiliated and nonaffiliated programs are operated in public and private institutions including VA and DOD hospitals. Revenues for operating training programs are derived from patient care (private and third-party payers) or from Federal, State, and local resources. The major source of financial support for graduate medical education training programs in the private sector comes from patient care revenues.

ESTABLISHING GRADUATE MEDICAL TRAINING PROGRAMS IN THE PRIVATE SECTOR

We contacted 16 medical schools and 33 teaching hospitals and interviewed 225 directors of graduate medical education training programs at 9 medical schools. We asked questions to identify or determine who made the decisions on the numbers and types of physician specialists being trained, factors influencing these decisions, and the extent to which training programs are coordinated to assure that the number and type trained are consistent with national needs.

Decisionmaking structure

At the medical schools, we were advised that decisions on the types and numbers of physicians trained are made, in most cases, by individual program directors.

Program decision responsibility at teaching hospitals varies depending on whether the individual graduate training program is affiliated with a medical school. For affiliated programs, decisions on the numbers and types of physicians trained are shared by the medical school program directors and hospital officials. Decisions of this type for nonaffiliated programs are made by hospital officials.

1/HEW stated it is not wholly accurate to identify 24,974 first-year graduate medical education positions in school year 1975-76 because many of these positions cannot be entered directly from medical school due to prerequisite graduate medical education requirements.

Factors influencing the establishment of graduate medical education training programs

Decisions on the types of graduate training programs established and the number of physicians trained are rarely based on any perceived national need.

Numerous factors bear upon or influence graduate medical education training decisions. However, the principal factors identified by the 225 program directors contacted at 9 medical schools were the availability of funds for graduate medical education and the patient care needs of the teaching hospitals. The availability of faculty and teaching facilities were also cited as important factors considered in making decisions about the number of specialists to be trained. A list of the factors most often cited is shown on page 42.

Although a number of studies have been made to determine how many physicians are needed within specialties, only 5 of 225 program directors said the size of their training programs was based solely on these studies. For example, a medical school program director at one university advised us that he and other directors of urology training programs in the Southeast voluntarily agreed to reduce the number of urologists in their training programs because of a manpower study which concluded that there was an oversupply of urologists in that area.

Reasons given by directors of graduate medical education training programs for not using the manpower studies to make program decisions include:

--The availability of funds for graduate training programs was the overriding consideration involved.

--The needs of hospitals were considered more important factors than manpower study data.

--Available data was not used because it did not apply to local needs.

--Although there was agreement with the study findings by some program directors, they were not used because graduates of these training programs continued to receive job offers.

Factors Cited Most Often by 225 Program Directors in Establishing Graduate Medical Education Training Programs

Factor	Number of directors citing factor (note a)	Percent of directors citing factor (note b)
Available funding for graduate medical education costs	140	62
Patient care needs of teaching hospitals	138	61
Availability of faculty	75	33
National, regional, State or local need for specialists	33	15
Balanced or quality medical education	31	14
Availability of teaching facilities	28	12
Minimum number of graduate medical students to have viable program	25	11

a/In many instances program directors cited more than one factor.

b/Two-hundred and twenty-five program directors were contacted. These percentages represent the directors citing the particular factor.

Action by several States in recent years has begun to affect the type and size of graduate medical education programs in State-supported institutions. Specifically, many States are taking action designed to affect the specialty mix of physicians being trained in order to meet their needs by making funds available for training additional primary care physicians. (See p. 62.) For example, officials in Minnesota, Wisconsin, and California said that State funds have been appropriated to specifically train more family practitioners. Legislation enacted in Nebraska also stipulated that expansion of graduate training positions at State-funded institutions after June 1976, in other than family practice, could occur only when the demand for such specialty training is shown by patient numbers and need.

Coordination among program directors in determining the number and type of physicians trained

At the medical schools and teaching hospitals visited, little or no consideration was given by individual program directors to identical training programs being offered elsewhere to develop a coordinated approach for training the approximate numbers and types of physicians needed.

The need for coordination of graduate medical training programs has been recognized, however, by the Executive Vice President of the National Intern and Resident Matching program. 1/ In an April 1976 report on the program, he pointed out that some form of coordination or national planning of graduate medical education process was essential if the system is to produce the appropriate number and types of needed practicing physicians. However, none of the program directors we contacted told us that they coordinated the number of physicians trained with other program directors in the same specialty.

The program directors contacted generally gave the following reasons or rationale for not attempting to do so:

--In the past there was always need for more specialists.

--Their goal is to train quality specialists and not satisfy a predetermined need for physicians in that specialty.

--Coordination would be useless since the need for a given type of specialist has not been established or mutually agreed upon within the profession.

--The nature of graduate medical education is competition, not coordination. There is competition among program directors for trainees and faculty, recognition, and research and training grants.

Selection of specialty training

Because undergraduate medical education is not generally considered adequate training for a physician to enter private practice, most States require students graduating from medical school to obtain a minimum of 1 year of graduate clinical training before being eligible for licensure. About

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1/The National Intern and Resident Matching program is discussed on p. 44.

90 percent of students graduating from U.S. medical schools select graduate specialty training through the National Intern and Resident Matching program. This program is a clearinghouse designed to help medical students select a graduate specialty training appointment at the hospital of their choice and to help hospitals select the medical students of their choice.

Participating students must apply to the hospitals for desired appointments and supply the program with a rank order list of positions for which they applied. The participating hospitals evaluate the applicants through interviews, tests, and review of medical school records and rank them according to their priority for acceptance into the program. The program matches the students' and hospitals' respective priority rankings and notifies both parties of the outcome. Not all medical students will be selected for a program of their choice nor will the hospitals get trainees for all their graduate medical education training positions.

Students not selected and institutions not participating in the matching process satisfy their mutual needs independently.

Factors which influence specialty choice

According to AMA, the choice of a specialty career in medicine is made because of the attractiveness of that career for the individual physician. The choice depends on such factors as status, financial return, intellectual challenge, opportunity for service, satisfactory working conditions, and recognition by professional colleagues and the public.

Studies by HEW, the National Academy of Sciences and others, show that numerous factors have an influence on a physician's specialty choice. These can be categorized into five areas: economic factors, social and demographic factors, personality factors, the influence of the medical school environment, and the influence of graduate medical training.

When the National Academy of Sciences 1/ asked 3,569, 1975 graduates of U.S. medical schools to rank the importance of 7 factors in determining their first choice of a specialty,

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1/National Academy of Sciences study on Medicare-Medicaid reimbursement policies, issued in Mar. 1976.

almost half (47 percent) considered the influence of a faculty member as 1 of the 3 most important in their choice of specialty. A strong interest in the area of specialization was considered either first, second, or third in importance by 94 percent of respondents, and expected life style was ranked by a third of those answering as one of the three most important factors in their specialty choice.

We sent questionnaires to a statistical sample of 1,995 of the 11,494 physicians who either graduated from medical school or were initially licensed to practice medicine in 1971. 1/ We asked several questions designed to identify the factors which influenced them in choosing their respective specialties.

Analysis of the factors chosen by the 1,470 respondents (see p. 46) shows a similar strong influence of faculty interest in the area of specialization and lifestyle in a physician's choice of a particular specialty.

Directors of graduate medical education training programs said that the decision to enter a particular specialty is generally made by the medical student alone, although some acknowledged that they attempt to influence the decision of a student. According to many program directors, the quality of training is the most influential factor in developing student interest in a particular specialty. In some instances, the directors may attempt to dissuade a student from entering a specialty if the student does not show a sincere commitment to it.

1/We selected 1971 graduates and licensures for our study because most graduate training programs require at least 3 years to complete. The majority, therefore, would have entered medical practice in 1974 and 1975.

Factors Influencing Specialty Choice of a Statistical Sample of 1971 Medical School Graduates and Licensees

Factor	Number of respondents ranking factor	Percent of respondents ranking factor	Number ranking factor 1, 2, or 3	Percent ranking factor 1, 2, or 3
An interest in the area of specialization	1,413	96	1,333	94
Influence by faculty member	1,346	90	605	4[illegible]
Need for more practicing physicians in the specialty	1,350	92	588	44
Life style (e.g., regular hours)	1,333	91	564	42
Availability of training positions in the specialty	1,340	91	447	33
Influence of family member or friend	1,336	91	382	29
Greater opportunity for research contribution	1,330	90	334	25
Other factors	148	10	117	79

CONCLUSIONS

Little is being done to insure that appropriate types of physicians are being trained in the United States. Most medical organizations do not appear to have the data needed to make rational decisions in this regard. Many professional medical organizations believe their sole responsibility should be the training of quality physicians and consequently do little to insure that an appropriate number are trained. Given the nature of the medical education system, we believe that major changes are required to insure the training of an appropriate mix of physicians. The type of changes needed are discussed in chapter 5.

THE FEDERAL ROLE IN GRADUATE MEDICAL EDUCATION

VA, DOD, and HEW support either directly, or indirectly, many graduate medical education training positions. VA and DOD are involved to meet the need for providing health care to their beneficiaries, and together they support about 8,000 graduate medical education training positions, or 15 percent of the Nation's total. Within HEW, the National Institute of Mental Health (NIMH) is involved in trying to increase the supply of psychiatrists in the Nation, while the National Institutes of Health (NIH) is interested in developing an adequate supply of medical researchers for the Nation. In addition, HEW's Social and Rehabilitation Service supports graduate medical (residency) training for physicians in physical medicine and rehabilitation and summer fellowships for medical students in the same specialties.

Each Federal agency operates its own program, with little, if any, coordination with other Federal agencies or between those in the Federal Government and in the private sector who operate identical graduate medical education training programs about the numbers and types of those trained.

Discussed below are the role and involvement of these organizations in graduate medical education training programs.

Role of the Veterans Administration

Even though the Veterans Health Care Expansion Act of 1973 gave VA responsibility for assisting in providing an adequate supply of health manpower to meet national needs, VA has not developed a plan to fulfill this task. While there appears to be general agreement on the need to train more primary care physicians, less than one-third of VA's graduate medical education positions are in primary care, and almost all of these are in general internal medicine. In addition, while many believe we may soon be training too many physicians in the United States, VA is increasing the number of medical schools and the overall supply of physicians to comply with Public Law 92-541.

Over the years the VA has become a major partner in and provider of resources to the Nation's system of health manpower education. VA operates the largest health care system under unified management in the Nation, and it supported the equivalent of about 10 percent of all graduate medical education positions in the Nation in school year 1974-75. During the 1975-76 academic school year, VA supported about 5,900 graduate medical education (resident) positions at an estimated cost for salaries alone of $116 million. Because of trainee rotations between VA facilities and affiliated institutions to fulfill educational curriculums, the number of physicians in the Nation receiving at least part of their clinical training in VA facilities is considerably higher. Accordingly, VA has a substantial impact on whether the Nation's supply of physician manpower is appropriate to meet national needs.

VA involvement in graduate medical training began more than 30 years ago. Until 1972 the primary objective of this training was strictly to provide quality health care for veterans.

However, in that year the Congress passed the Veterans' Administration Medical School Assistance and Health Manpower Training Act of 1972 (Public Law 92-541) in an attempt to improve VA's ability to train needed health professionals and provide leadership to the Nation's medical community in developing health manpower education and training programs. At that time, there was a perceived national shortage of physicians and allied health personnel—an estimated shortage of about 48,000 physicians and more than 250,000 allied health and other medical personnel. Accordingly, the 1972 act authorized the Administrator of VA to provide grant assistance for establishing new State medical schools and expanding existing medical schools affiliated with VA, among other things.

At the time of our review, VA had approved five of the six formal applications it had received for establishing new State medical schools and was funding four of these. In addition, VA had awarded a total of 18 grants to existing medical schools and 102 grants to programs for education in other health professions and occupations to assist them in expanding and improving their capacity for educating health professional students. Shown below are total authorizations, appropriations, and obligations under the Veterans' Administration Medical School Assistance and Health Manpower Training Act of 1972.

	Fiscal Year			
	1973	1974	1975	1976
Authorization	$75,000,000	$75,000,000	$75,000,000	$75,000,000
Appropriation (note a)	20,000,000	25,000,000	10,000,000	30,000,000
Obligations	-	8,483,000	25,200,000	b/39,602,000

a/Appropriated funds remain available for 6 succeeding years following the fiscal year in which appropriated.

b/Estimated.

The following year the Congress passed the Veterans Health Care Expansion Act of 1973 (Public Law 93-82). Among other provisions, section 201 expanded the primary objective of VA's graduate medical education program to assist in providing an adequate supply of health manpower to meet national needs to the extent feasible without interfering with the medical care and treatment of veterans. Nevertheless, the Chief Medical Director, Department of Medicine and Surgery, advised us in May 1976 that VA has no plan for dealing with the physician specialty distribution issue facing the Nation.

In fiscal year 1975, VA participated in 988 graduate medical education training programs for physicians. These programs represented all accredited clinical specialties and subspecialties in medicine and surgery, except for areas such as pediatrics and obstetrics, in which no VA patient care programs existed.

Specialty mix of VA-supported graduate medical training positions

VA's Department of Medicine and Surgery apparently maintains little, if any, control over the type or specialty mix of residents rotating through VA hospitals. Rather, we were advised that the specialty mix of residents is determined jointly by each VA hospital and its affiliated medical school. During fiscal years 1974-76 VA-supported graduate medical education (resident) positions increased by about 12 percent (630 positions). An analysis of the increase by specialty shows that:

--General internal medicine positions increased as a percent of total VA-supported positions from 31.27 percent in fiscal year 1974 (1,657 positions) to 32.56 percent in fiscal year 1976 (1,930 positions).

--Internal medicine subspecialty positions increased as a percent of total VA-supported positions from 8.39 percent in fiscal year 1974 (444 positions) to 9.63 percent in fiscal year 1976 (571 positions).

--Surgical positions as a percent of total VA-supported positions decreased from 35.07 percent in fiscal year 1974 to 32.76 percent in fiscal year 1976. However, the number of surgical positions supported during that time increased from 1,858 positions to 1,942 positions.

--VA support of family practice positions, which is reported for the first time in fiscal year 1976, consisted of 11 positions, or less than 1 percent of all VA-supported positions.

The Chief Medical Director told us that VA is not viewed by others as a resource for supporting family practice positions due to its inability to provide training in pediatrics, obstetrics, and other specialties in which no VA patient care programs exist. The number of family practice positions supported financially by VA is not likely to increase significantly in the future. We were advised that VA is providing training opportunities for many family practice residents as part of its residency rotation program. However, it financially supported an average of only 11 such positions during fiscal year 1976.

Conclusions

As discussed on page 34, the Secretary of HEW in November 1975 said that adequate numbers of health professionals will soon be in practice in the Nation, and instead of an overall physician shortage, the Secretary identified two more pressing problems, one of which concerned physician specialty maldistribution. Furthermore, the 1976 Carnegie Council study, as discussed on page 34, concluded that the physician shortage appears to have ended and therefore recommended that VA's authority to provide Federal funds for new medical schools be repealed by the Congress.

Accordingly, the question arises as to whether VA should continue to have authority for providing Federal funds for developing new medical schools or increasing the capacity of existing medical schools--a role VA objected to on the grounds that this responsibility should be vested in the agency charged by the President with primary responsibility for implementing the national health strategy (i.e., HEW)--when many believe we may be training too many physicians.

Role of the Department of Defense

DOD conducts its own graduate medical education training programs in order to develop an adequate number of physician specialists to meet both peacetime and wartime patient care needs. About 90 percent of its physicians received their training in DOD facilities and the remainder in civilian facilities. Graduate medical education training programs in DOD facilities, although not affiliated with medical schools, are accredited. Each military department conducts its own graduate medical education training with the Army, Navy, and Air Force supporting approximately 41 percent, 35 percent, and 24 percent, respectively, of those in training during 1976.

Physician needs for DOD are reportedly determined as follows: given certain requirements for physician specialists, available current numbers of physicians in each specialty are ascertained. Estimates are then made of how many physician specialists by specialty will be available 6 months, 12 months, 2 years, 5 years in the future. Resignations, end of commitments, deaths, etc., are estimated. These estimates are based on the best historical information available and are tempered by judgment of how future personnel policies, economics, national moods, etc., will affect the probabilities that an individual will remain in the service. A comparison is then made of requirements based on wartime and peacetime needs, and attempts are made to determine if a shortage or surplus exists in each specialty area by month and year.

Graduate medical education training programs are then adjusted to reflect the need for more or fewer participants for each specialty. Continuing review of the needs and revised estimates of the supply are carried out to adjust the number of participants in training in line with the best available information.

During fiscal year 1976 (school year 1975-76), DOD supported about 2,100 graduate medical education positions. About 90 percent of the physicians received their training in DOD facilities and the remainder, in civilian facilities. The number and type or specialty mix of DOD-supported positions during fiscal years 1974-76 remained fairly stable. Primary care specialties increased as a percent of total DOD-supported positions, however, from 33.68 percent in fiscal year 1974 (683 positions) to 34.75 percent in fiscal year 1976 (729 positions). Most of the increases occurred in family practice. Nonprimary care specialties decreased as a percent of total DOD-supported positions, from 66.32 percent in fiscal year 1974 to 65 25 in fiscal year 1976, although the total number trained increased.

Role of the National Institutes of Health

The National Institutes of Health is the principal biomedical research agency of HEW. It supports, among other things, research training programs for physicians and other professionals to provide a cadre of highly trained individuals to conduct research. While NIH does not generally support graduate medical education training programs, per se, a number of physicians, supported by its research training grants, are in graduate medical education training programs which may subsequently be credited for or toward board certification, primarily in the nonprimary care specialties. A 1975 report of the committee, which studied national needs for biomedical research personnel, indicated that many physicians participating in NIH-supported research training programs began medical practice soon after completing their training instead of making a career in research. Therefore, although directed toward developing a cadre of trained physicians to conduct research, NIH's support has nevertheless provided the opportunity for many physicians to obtain graduate medical education training in the nonprimary care specialties.

Through 1972, almost 94,000 individuals had participated in NIH research training programs since they began in 1938. Most of the training had occurred in the last decade since about 85 percent of the trainees started their training since 1961. About 25,000, or 27 percent, of the 94,000 trainees were physicians who had completed their undergraduate medical schooling when they first received NIH-supported research training.

On July 12, 1974, the President signed the National Research Act (Public Law 93-348), which amended the Public Health Service Act "to establish a program of National Research Service Awards to assure the continued excellence of biomedical and behavioral research." This act expresses the Congress' view that direct support for careers in biomedical and behavioral research is an appropriate and necessary role for the Federal Government.

The law authorizes awards (fellowships) for research training to individuals and grants to non-Federal public or nonprofit institutions, which in turn select individuals for such awards. Award recipients must give assurance they will meet a service agreement--engage in health research or training, or alternatively

--serve as members of the National Health Service Corps or

--serve their specialties in a geographic shortage area in that specialty or in a health maintenance organization which offers care in a medically underserved area.

Recipients who fail to comply with the service requirement must repay the amount of their awards plus interest.

Effective July 1, 1975, research training awards under title I may be made only in those subject areas in which there is need for personnel. This is determined by a continuing study, which the Secretary of HEW had requested the National

Academy of Sciences to conduct. Moreover, among the other provisions, the act specifically states that "National Research Service Awards may not be used to support residencies." In the Public Health Service manual of laws and regulations, section 66.102(q), residency is defined as "* * * postgraduate training for doctors of medicine, osteopathy, dentistry, optometry, and podiatry, nurses, and other individuals providing health care directly to patients where the majority of their time is spent in non-research clinical training."

During our review at 9 medical schools we were advised that a total of 219 graduate medical education training positions had been supported with NIH research training funds during academic school year 1975-76. NIH officials told us they do not collect the type of data necessary to indicate the extent to which this situation may have occurred. The National Research Act included a grandfather provision permitting the continuation of programs previously approved under conditions prevailing at that time. Research training grants used to support graduate medical education training positions at the medical schools we visited fall in this category and were authorized before enactment of this act. NIH officials told us that research training grants authorized before the National Research Act will be terminated at the end of their project periods and those institutions wishing to continue their research training program will have to compete under the new National Research Act authority.

Role of the NIMH

The National Institute of Mental Health has supported the graduate medical education training of physicians in psychiatry since it began in 1948. Its objective has been to increase the supply of psychiatrists in the Nation and to strengthen the capacity of institutions to provide training.

NIMH's basic mission is to improve the mental health of the U.S. population through developing knowledge, providing services, and training manpower to promote and sustain mental health, prevent mental illness, and treat and rehabilitate the mentally ill. NIMH has legislative authority to support both clinical and research training programs and has supported the graduate medical education training of physicians in psychiatry under both program types.

Legislative authority for clinical training supported by NIMH is contained in section 303 of the Public Health Service Act, which provides for training and instruction to individuals and for investigations and studies relating to the care, treatment, and rehabilitation of the mentally ill. That authority has been continued in the conforming amendments section of the 1974 National Research Act.

With the founding of NIMH in 1948, the Government began directly supporting the teaching of medical students and the graduate medical education training of physicians in psychiatry. Support soon followed for training programs in child psychiatry, behavioral sciences, psychoanalysis, and a variety of other education programs. The largest amount of training support, however, went for basic graduate medical education programs which began slowly and developed over time. NIMH has provided psychiatric training support to an estimated 7,500 physicians from 1948 to 1968.

NIMH does not have information readily available on the actual number of psychiatric positions supported during the last few school years. Available data shows the number of grants and stipends awarded directly to the training institutions, and these include funds for teaching costs as well as stipends. The trainees receiving the stipends are selected by the institutions. NIMH awarded 289 grants, including 887 stipends totaling about $23 million in school year 1975-76, and most, if not all, of the recipients were physicians in graduate medical education programs in psychiatry.

Although the number of stipends authorized has decreased in recent years, NIMH still supports many positions in both basic and child psychiatry programs. We estimated that this support covered about 16 percent of the filled psychiatric positions in the Nation in the 1975-76 school year.

In the summer of 1975, NIMH created a mental health services manpower task force to address manpower problems in the area of mental health. On the basis of its findings and other deliberations, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) 1/ has proposed a major reduction of the NIMH clinical training programs. Clinical training will be part of a broader manpower development strategy which includes research and development activities in distribution, recruitment, and retention of mental health manpower; manpower

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1/ADAMHA is that part of the Public Health Service that provides leadership in the Federal effort to combat the problems of alcoholism, drug abuse, and mental health. It is comprised of NIMH, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse.

utilization; the development of manpower data systems; the training of primary care practitioners in the mental health field; and the strengthening of State manpower planning and development programs.

HEW stated that continued support for the basic education of psychiatrists, psychologists, social workers, and psychiatric nurses is planned in ways that will be more closely related to demonstrated State and local service needs. Emphasis in training will be on improving: (1) preventive services, (2) services to underserved regions (that is, dealing with geographic maldistribution) and underserved populations (e.g., children, aged, minorities), and (3) community services as alternative to long-term hospitalization.

HEW also stated that ADAMHA strongly supports extended training of primary care physicians in the prevention, diagnosis, and treatment of emotional disorders and substance abuse. In addition, there was mention of the severe maldistribution of psychiatrists, and that changes in the Immigration and Nationality Act may worsen this distribution by decreasing the number of alien foreign medical graduates entering the United States. Although HEW stated that the following issues deserve further study, they mentioned that the availability of psychologists, psychiatric nurses, social workers, alcohol and drug counselors, and other mental health workers can positively affect the availability of mental health services, thus influencing the need for psychiatrists.

CHAPTER 4

MEDICAL PROFESSION, STATES, AND FEDERAL EFFORTS TO TRAIN APPROPRIATE NUMBERS AND TYPES OF PHYSICIANS

Presently no public or private organization has overall responsibility for developing and implementing a system to see that the number and types of physician specialists are consistent with the approximate number needed.

WHAT ROLE DO MEDICAL PROFESSIONAL ORGANIZATIONS HAVE?

We asked 83 medical professional organizations a number of questions to determine what role, if any, their organizations have to insure that appropriate numbers and types of physicians are trained to meet national needs. While almost all the 79 organizations responding said they were concerned with policy matters affecting graduate medical education, accreditation of graduate training programs, and certification of physicians choosing to practice in a specialty, none said they had overall responsibility for seeing that the number and types of physician specialists and subspecialists trained were consistent with the approximate number needed in the Nation.

The specialty boards, residency review committees, and CCME all stated it was their concern but not their role to see that the number of physicians trained is consistent with the approximate number needed.

The specialty boards are primarily responsible for determining the competence in the fields of candidates who appear voluntarily for examinations and, for certifying as diplomates those who are qualified. To accomplish this, specialty boards determine if candidates have received adequate preparation in accordance with established educational standards. They also conduct comprehensive examinations to determine the competence of such candidates and certify the competence of those physicians who have satisfied the requirements. Three specialty boards outlined their role in pertinent part as follows:

—"The American Board of Surgery was formed in 1936 * * *: (1) To conduct examinations of acceptable candidates who seek certification by the Board; (2) To issue certificates of qualification to all candidates meeting the Board's requirements and satisfactorily

> completing its prescribed examinations; and (3) To improve and broaden the opportunities for the graduate education and training of surgeons. The Board has, since its organization, specifically limited its responsibilities and activities to fulfilling the purposes stated above. The Board has consistently refrained from entering other arenas of interest to surgeons and their patients or the public. It has conducted no studies, assembled no data and as a functioning body has formed no opinion regarding surgical manpower in the United States. Since it has no authority nor responsibility in this matter, it has refrained from making any judgment or statements regarding it."

> --"The American Board of Dermatology has a very definite interest in the number of physicians who are entering our specialty, but we do not have a direct role in determining the adequacy of the number of dermatologists or in increasing the number. It is the responsibility of the Board to control quality of the persons entering our specialty rather than quantity.'

> --"You should understand that under our [The American Board of Radiology] charter and bylaws we are an examining and accrediting body whose primary interests are in the design, length and content of training programs and the qualifications and knowledge of those trainees who complete these accredited programs. Our policy regarding numbers of trainees in Radiology and its various branches has always been predicated on the adequacy of the training facilities and faculties in relation to the number of trainees. The Board has not been assigned the task of determining the needs for radiologists in the United States."

The residency review committees generally stated that it was their responsibility and function to evaluate the educational quality of graduate medical education training programs or standards for accreditation of such programs, which are specified in the "Essentials of Approved Residencies" published annually by AMA. We were told that the number of accredited graduate medical education training positions is determined based on the quality of the educational experience and on the opportunity for acquiring the skills which are provided in a particular training program. For example, three of the residency review committees outlined their roles in pertinent part as follows:

--"The Residency Review Committee carefully reviewed your inquiry as well as its own function and responsibilities. The Committee, which is composed of representatives of two parent bodies (The American Medical Association and The American Board of Physical Medicine and Rehabilitation) limits its activities to evaluation of residency programs in this specialty in terms of their meeting the essentials of approved residencies. The Committee is concerned with the quality of educational programs and does not become engaged in quantitative manpower issues such as the establishment of the number of residency programs or the number of residents serving in any such residencies. * * * Also, because its role is limited to the assessment of quality of the educational programs, the Committee is not in a position to respond to the questions posed in your letter regarding manpower requirements in the specialty."

--"Our mission is to determine whether or not the residency program under review is a sound one based entirely on its educational qualities. To put it another way, it is our responsibility to see the programs are of high quality so that all trainees will become proficient in order that patients with thoracic and cardiovascular surgical problems will receive the best possible treatment. The need to render service by the trainee to the institution is never considered in our evaluation."

--"From the above, it is evident that we have no direct responsibility with either increasing or decreasing the numbers in our specialty. Indirectly we may eventually decrease the numbers by upgrading the standards required for residency approval. Conversely, if a large number of excellent programs are presented to us, we would have to approve them."

--"The Residency Review Committee in Ophthalmology is made up of members appointed by the AMA Council on Medical Education and the American Board of Ophthalmology. Its function and responsibility is to evaluate the educational quality of residency and fellowship programs in ophthalmology based on standards for accreditation of programs which have been developed and are published. The number of residency positions accredited are determined on the basis of the quality of the education experience and upon the opportunity for acquiring skills provided by a particular ophthalmology residency program."

--"The committee believes that it is not in a position nor is it its responsibility to determine the quantitative needs nor the distribution of ophthalmologists throughout the United States. Any opinion of the Residency Review Committee in Ophthalmology on supply and demand would have to depend upon information from other groups."

CCME is responsible for reviewing matters affecting all levels of medical education and recommending policies to its five constituent organizations for their adoption and implementation. It also coordinates the activities of its liaison committees. CCME told us that it would be a considerable extension of its current activities and philosophy to say that it should be responsible for determining the appropriate types of specialty physicians needed in the United States.

Most of the 29 responding specialty and subspecialty societies, which are usually recognized as the spokesperson organizations for practicing physicians, either stated it was not their role to assure that the number of physicians trained is consistent with national needs or did not specifically respond to the question. Although some societies commented on actions they have taken to develop additional manpower in their specialties, it was unclear if they believe they have specific roles in insuring that appropriate types of physicians were being trained. On the other hand, the American Academy of Family Physicians said it hopes to have an increasing role in seeing that enough family physicians are trained to meet the needs and has established a goal of having sufficient first-year graduate medical education training positions to accommodate at least 25 percent of the U.S. medical school graduates each year.

The American Academy of Dermatology outlined its role in dealing with the physician manpower issue as follows:

--To prepare a comprehensive, accurate, and objective analysis of future manpower needs in which the many variables are assessed and to make this information available to health planning agencies, medical schools, and training program directors.

--To propose, where indicated, specific recommendations to planning agencies, medical schools, schools of allied health professions and training program directors for action based on the foregoing assessment.

—To support in every way possible the educational system at all levels and thereby increase productivity, improve quality of care, and ensure adequate training and experience for physicians who may provide dermatological care.

However, under the present medical education system, implementing a specialty society's recommendations to adjust the number of physicians trained in a particular specialty or subspecialty would, in almost all cases, be voluntary on the part of the training institutions and the several thousand individual directors of graduate training programs located throughout the United States.

DO THE MEDICAL PROFESSIONAL ORGANIZATIONS BELIEVE A NEED EXISTS TO CONTROL OR REGULATE GRADUATE MEDICAL EDUCATION?

The majority of medical organizations responding to our question believed that an appropriate distribution of physicians by specialty could be achieved through the law of supply and demand and that it was not necessary to control or regulate the graduate medical education process.

Specifically, of the 79 medical professional organizations responding, 33 believed that appropriate numbers and types of physician specialists and subspecialists to meet national needs could be achieved through the law of supply and demand, 44 organizations either did not express an opinion on this or did not respond to the question, and 2 believed that some form of control or regulation over the graduate medical education process was necessary.

A consensus of the organizations favoring the free market approach stated that an appropriate distribution of physicians by specialty is in process of being achieved, and pointed to the increasing number of physicians engaged in primary care training. One organization stated that it will be achieved by the medical profession as part of the supply and demand model for health care services. Others pointed out that while the free market system is not perfect, it is the best approach and has worked to change the distribution of specialists in the past.

Conversely, a majority (138 of 225) of the program directors responsible for establishing and operating graduate medical education programs expressed the opinion that control or regulation over the graduate medical education process was needed. They indicated that in the past, supply and demand simply had failed to properly match the number and types of specialists trained with the need for their services.

WHO SHOULD BE RESPONSIBLE FOR DETERMINING THAT APPROPRIATE NUMBERS AND TYPES OF PHYSICIANS ARE BEING TRAINED?

Most medical organizations contacted believe that if control or regulation over the graduate medical education process is undertaken, it should be exercised by the medical profession itself, through CCME. Although it would be in a position to assume this responsibility, CCME told us that it has not yet decided what future role, if any, it should play in determining an appropriate specialty distribution of physicians.

If control or regulation over the medical education process was undertaken at all, 25 residency review committees, specialty boards, and specialty societies favored CCME assuming this responsibility although 3 did not and 34 expressed no opinion.

Among the five constituent member organizations comprising CCME, AAMC, and AHA both believe that CCME should assume responsibility for determining the appropriate number and types of specialty physicians needed in the United States. The ABMS told us that it has not taken an official position on whether any organization should assume this responsibility and the CMSS did not specifically respond to our questions. AMA took the position that there is no need for control or regulation and it would be inappropriate for CCME to assume this responsibility.

In explaining its position, AAMC pointed out that responsibility for designating available graduate medical training positions on the basis of national manpower needs on the one hand and the responsibility of accreditation of graduate medical training programs on the other hand should be specifically and intentionally separated. AAMC believes it is inappropriate to use the power of accreditation to limit or expand the number of physicians a graduate medical education program can enroll to achieve national needs. Rather, designation of training positions which may be filled to achieve national goals should be accomplished independently by an independent organization. According to AAMC, CCME, because of its relationship to the LCGME, is an appropriate organization which could accomplish this task while still maintaining the integrity of the accreditation system and the quality of graduate medical education.

AHA stated CCME and LCGME could very appropriately monitor the training of different types of physicians and make recommendations concerning projections of need. AHA further believes this can be accomplished without setting CCME in a regulatory arrangement.

AMA takes a different position. It believes it is neither necessary nor appropriate at present to have any public or private organization assume a role of prescribing or regulating the number and types of physicians. It believes it and other medical organizations can play an important role in influencing these matters by bringing information on the present and projected supply of physicians to the attention of the profession and the public and giving some indication of the special areas of need by medical specialty. According to AMA, through such information, it is possible for the profession and the public to provide encouragement and special incentives to influence physicians in training to enter certain fields of education and practice. AMA pointed out, however, that such an approach does not call for creating a new regulatory body or assigning regulatory powers to an existing organization or body.

CCME told us that its committee on physician distribution is currently engaged in preparing an extensive report on "The Specialty and Geographic Distribution of Physicians." When the report has been completed and approved by CCME, it will then be forwarded to the five constituent organizations for their consideration and, if approved by all five, it will become official CCME policy. We were told that no decision had been made by CCME and its constituent organizations as to what future role it should play in determining the approximate distribution of physician specialists required to meet national needs.

In order for CCME to take a position on any issue it requires unanimous prior approval for such action by its five constituent organizations.

STATES' ACTIONS TO BRING ABOUT APPROPRIATE NUMBERS AND TYPES OF PHYSICIAN SPECIALISTS

Many States are acting to affect the specialty mix of physicians trained. State higher education offices and legislatures are conducting studies of physician specialty distribution and are taking steps to increase primary care training positions.

Efforts of State higher education offices to deal with physician manpower needs

The States' higher education executive officers are responsible, in their individual capacities, for planning and coordinating programs for health manpower education in their States. Besides making physician manpower studies, many State offices of higher education act as governing boards for State institutions of higher education, including medical schools. Therefore, they are involved in undergraduate and graduate medical education.

There have been several studies on medical education by State offices of higher education. Some include recommendations to State legislatures to affect the specialty distribution of physicians trained. For example, the Tennessee Higher Education Commission issued a report in 1971 on medical education as part of its responsibility to design a master plan for higher education. The report concluded Tennessee should attempt to achieve by 1980, a physician to population ratio at least equal to the 1967 national average. In addition, its report noted a need for more general practitioners, pediatricians, obstetricians, and others serving in primary patient care. In 1974 Tennessee established a Statewide family practice graduate training program and authorized at least 100 additional family practice positions in the next 5 years.

In a 1975 report, the Illinois Board of Higher Education recommended that at least one-half of all first-year graduate medical education training positions be in the family practice, internal medicine, and pediatrics specialties. In addition, the report recommended that the State of Illinois give financial support for the new first-year positions in primary care specialties. A bill introduced in the Illinois Legislature in 1975 to fund family practice graduate training programs failed to pass because of financial problems in the State, according to a summary of State legislation and funding for family practice programs prepared by the American Academy of Family Physicians in January 1976. The legislation was not reintroduced in 1976 because of continuing financial problems.

State efforts to increase the number of primary care physicians

Funds have been made available in about 40 States for training primary care physicians, either through specific legislation or general support of State-supported medical schools. For example:

--Oklahoma House Bill No. 1552 was enacted in 1975 to support graduate medical education in internal medicine, obstetrics and gynecology, pediatrics, emergency trauma, and family practice.

--Kentucky Senate Bill No. 28 was enacted in 1976 to support graduate medical education in family/general practice, general pediatrics, general internal medicine, emergency medicine, and general obstetrics and gynecology.

--At the direction of the State legislature, the University of California's five medical schools established a goal in January 1974 of having 43 percent of their graduate medical education training positions in the primary care specialties by 1979. In developing plans for attaining this goal, they recognized that some medical schools have facilities and faculty that were oriented to primary care, while others are oriented to nonprimary care training. Therefore, individual goals were established for each school to attain the overall goal. Legislation has been enacted to provide $4.5 million for family practice programs (1978-81). Other primary care specialties have been funded from general university funds in past years, and this is expected to continue.

In responding to the draft report, the American Academy of Family Physicians told us that 16 States had passed a total of 21 bills specifically to support family practice training programs.

FEDERAL EFFORTS TO DEVELOP APPROPRIATE TYPES OF PHYSICIANS

Direct Federal involvement in attaining an appropriate distribution of physicians by specialty, which are needed to meet the health care needs of the U.S. population, has been limited. Since 1963 Federal involvement has consisted primarily of programs designed to increase the total supply of physicians in the Nation. However, with enactment of the Comprehensive Health Manpower Training Act of 1971 and, to a greater degree, the Health Professions Educational Assistance Act of 1976, the Congress attempted to deal with the issue by directly supporting those institutions and trainees in graduate primary care training programs, especially in family practice.

HEW Graduate Medical Education National Advisory Committee

On April 20, 1976, the Secretary of HEW established the Graduate Medical Education National Advisory Committee (GMENAC). Among other things, this Committee was given responsibility for analyzing physician specialty distribution and evaluating alternative approaches so that the number and types of specialists and subspecialists trained is consistent with the Nation's needs. This Committee was also given responsibility for encouraging organizations, which control the number and types of graduate training positions, to provide leadership in achieving the recommended balance. For fiscal year 1977, the Congress appropriated $1 million for this Committee.

The Committee consists of 21 members selected by the Secretary or his designee. Three are ex officio members who are representatives of the Public Health Service, DOD, and VA. Of the remaining 18, 14 are medical and osteopathic physicians. Committee membership appears in app. XIII. Staff and management services for the Committee come from HEW's Bureau of Health Manpower, Health Resources Administration, and from a Program Officer, who serves as Executive Secretary. The first three meetings of the committee were held in June, September, and December 1977, respectively.

The Committee is responsibile for advising, consulting with, and making recommendations to the Secretary of HEW on the overall strategies on the present and future supply, and requirements of physicians by specialty, and translating these requirements into a range of types and numbers of graduate training opportunities needed to approach a more desirable distribution of physician services. These strategies are to take into account national health planning goals, guidelines, standards, and, as appropriate, the health systems plans developed by health systems agencies; factors which influence specialty distribution and the availability of training opportunities, including systems of reimbursement of services and financing of graduate medical education to the provision of services in training institutions, including alternatives for the provision of these services.

In addition, the Committee is to advise on data requirements and systems needed to conduct the activities of the Committee; propose national goals for the distribution of physicians in graduate training; and recommend Federal policies, strategies, and plans to achieve established goals in concert with the private sector and non-Federal agencies.

It should be recognized that to discharge the responsibilities it was given by the Secretary of HEW, the Committee will first have to secure the desired information and data from the medical profession. Once the necessary data is made available, the Committee will then need to (1) determine the present and future supply and requirements for physicians by specialty and subspecialty, (2) establish recommended national goals for the distribution of graduate medical education training positions, and (3) encourage organizations controlling the number and types of graduate training positions to provide leadership in achieving the recommended balance. At present, however, the most direct way to implement any restructuring in the size and type of graduate medical education training programs which are determined necessary by the Committee to meet national needs, is to encourage the medical profession, through its accreditation process, to implement necessary changes. Therefore, it appears that the Committee may face serious constraints in attempting to discharge these responsibilities.

CONCLUSIONS

Efforts to see that appropriate numbers and types of physicians are trained in the United States have been fragmented. However, most medical organizations believe that, left alone, the law of supply and demand will insure proper distribution of physician specialists.

If control or regulation of the graduate medical education process is undertaken, most members of the profession believe it should be done by the profession itself--through CCME. CCME, however, has not yet agreed to assume this role. Its constituent agencies are divided on this issue. We believe CCME is the most appropriate organization [illegible] present to deal with the issue and to take affirmative action. While the States have performed noteworthy actions, they are not in the position to exercise the same amount of control as CCME. In addition, the HEW Graduate Medical Education National Advisory Committee may face serious constraints in attempting to perform its responsibilities.

CHAPTER 5

CONCLUSIONS, COMMENTS BY MEDICAL PROFESSION AND COGNIZANT FEDERAL AGENCIES, AND RECOMMENDATIONS

Much has been written about problems regarding physician specialty distribution and many assertions have been made. Professional opinion seems to be that there are not enough primary care physicians--a conclusion based on professional opinion, rather than a scientific study. Allegations have also been made that there is an oversupply of certain specialists which may result in excessive medical or surgical procedures.

Information we obtained from numerous medical organizations tended to support the belief that more primary care physicians are needed, but not the belief that there are too many specialists. In fact, no specialty organization which we contacted believed that its specialty was in oversupply.

Despite the volume of material that has been written about this problem and the extensive hearings that have been conducted by congressional committees, we believe there is still not enough information on which to draw valid conclusions about the nature and extent of the specialty maldistribution problem. To reach sound conclusions, some basic questions must be answered.

What is a primary care physician? Opinions vary considerably on this question. Many believe that family practitioners, general practitioners, general internists, pediatricians, and obstetricians/gynecologists should be considered primary care physicians. Some believe that obstetricians/gynecologists do not belong in this group. Psychiatrists, dermatologists, opthalmologists and other specialists have indicated that they should be considered as primary care providers. The extent to which an internist who subspecializes should be considered as a primary care provider is not clear.

In addition, it is common knowledge that many specialists provide primary care to their patients, and many patients go directly to a specialist without first seeing a primary care physician. There seems to be a growing concern within the profession about how best to deal with this situation.

There is a question of how many physicians are needed? The total number of practicing physicians has increased dramatically during the past decade and will undoubtedly continue to rapidly increase. The ratio of physicians per 100,000 U.S. population has increased from 153 in 1965 to 197 in 1976 and is expected to reach at least 220 by 1990. The question remains: is this enough or too much?

We believe the best way to answer the question about total number of physicians needed is first to determine the number of each type of specialist needed. The sum total of the various types of specialists would then approximate the total number needed after first considering the interrelationships between various specialties.

In addition, a decision must be made on the number of physician extenders needed since hundreds are entering the medical care system each year, and the number being trained is growing.

Arguments have frequently been made that the medical profession will work out its own problems if left alone. As indicated by our review, few professional organizations are in a position at this time to suggest the appropriate number of specialists needed. Furthermore, most professional organizations stated that determining an appropriate number was not within their purview and that their concern was primarily educating quality specialists.

Discussions with medical school and teaching hospital officials indicated much the same situation, that is, a concern about the quality but not the quantity of physicians trained. Consequently, these sources are unlikely to answer soon the question of how many and what types of physicians should be produced.

Prior to the availability of our draft report for comment, CCME, which appeared to be in the best position to deal with the specialty distribution problem, had not taken a position on the problem and what needed to be done about it. Since CCME is composed of members of various professional organizations, it appeared to be in a better position than HEW's GMENAC to obtain the necessary data to deal with the problem. In addition, since CCME's LCGME is actively involved in reviewing and approving graduate medical education programs, CCME appeared to be in the best position to control the number and size of approved programs.

For this reason, we proposed in our draft report that CCME should play an active role in determining the number and type of specialists needed and in implementing procedures to see that necessary changes are made. We also proposed that HEW determine the number of physician extenders needed and CCME consider their impact on the number and types of physicians needed. If CCME did not agree to perform this function, we expressed the view that HEW should attempt to fulfill this role and use its funding authorities to influence the number and types of graduate programs, as appropriate. While answers to these questions were being obtained, we proposed that HEW and VA continue to fund primary care programs and increase the number of primary care providers.

MEDICAL PROFESSION COMMENTS

CCME

CCME told us that in addition to the quality of medical education at all levels, one of its abiding concerns has been the public's perception of the geographic and specialty maldistribution of physicians, and consequently, it has been studying these problems extensively. CCME agreed that additional detailed information is needed on which to predict future needs and policies. It pointed out that much data on physician distribution has already been accumulated and is presently available to the Federal Government, the medical profession, and the general public. It indicated that extensive correlation and analysis of data on public needs for general versus specialized medical care will be required before appropriate recommendations can be drafted to serve as a rational basis for national policy for training an appropriate mixture of physicians.

CCME also agreed that it should accept the responsibility for collecting the necessary information, analyzing and correlating the data, and making recommendations for the education and training of physicians, insofar as it already has responsibility for policymaking regarding the education and training of physicians. More specifically, CCME stated that it firmly believes

(1) that the Nation's needs for various kinds and numbers of medical specialists may be analyzed within reasonable limits;

(2) that the use of ratios to determine the adequacy of physician supply by specialty is an overly simplistic approach which is inadequate to provide a reasonably accurate assessment of the Nation's need for physicians;

(3) that the accreditation process in graduate medical education is devoted solely to considerations of quality and that accreditation should not be used to control either numbers or kinds of specialty training programs;

(4) that CCME should attempt to achieve the desired goal of matching the ongoing production of physicians to the changing needs in the country for medical care without the difficulties and implications involved in regulation, either by the Government or by any organization in the private sector;

(5) that CCME should determine the impact of physician extenders on the number and type of physicians needed; and

(6) that in view of the ongoing activities of the CCME as stated above and the probability of duplicative and possibly conflicting activities, the CCME recommends that the continuation of HEW's GMENAC be reconsidered.

AHA

AHA told us that it supports the comments and recommendations of CCME but challenged the assumption that the need for numbers of different physician specialists can readily be determined. In light of the complexity of issues, AHA proposed that Federal funds might best be spent on a feasibility study to determine the means for assessing population needs for various kinds of physician specialists and for recommending ways to govern the supply.

CMSS

CMSS 1/ commented that a general consensus exists that the report is correct in its assumption that CCME is the best available organization to assume responsibility for overseeing the number and types of physicians being trained, to attempt to ensure that these are sufficient for the optimal health care of the American people. According to CMSS, the CCME has as its parent organizations those organizations best able to obtain information and implement any necessary changes. Furthermore, CMSS stated that these are fitting responsibilities for those parent organizations.

1/The CMSS position represents a coordinated response with respect to comments received by 13 of their 20 member organizations.

According to CMSS, strong support exists in its responding organizations for CCME's assuming the responsibility proposed in our draft report. The principal disagreement with this CCME role, among CMSS members, was as to whether the regulatory function of physician manpower production would be part of this process. Half of CMSS member organizations commenting on the regulatory aspect favored CCME assuming this function although the other half felt that CCME should not be a regulator.

CMSS also told us that a consensus was apparent among its responding member organizations that any recommendations on the numbers and types of physicians produced should be voluntarily achieved through efforts of those in the private sector responsible for graduate medical education and training and not under regulations promulgated by HEW.

If, for some reason, CCME cannot assume responsibility for overseeing this complex situation, CMSS suggested that other alternatives be considered before turning this matter over to the public sector.

ABMS

ABMS told us it participated in developing the principles expressed in the previously discussed CCME response. It pointed out, however, that prior to receiving our draft report, ABMS expressed its belief that CCME's role should go beyond a passive one of data collection and analysis to include a possible regulatory role in the distribution of residency positions in all specialties.

Specifically, ABMS indicated it believes that CCME should assume a strong leadership role which probably can be discharged only by assuming responsibility for monitoring the size, number, and distribution of training programs. In this regard, ABMS believes CCME should discuss with the Secretary of HEW ways by which CCME may achieve the desired goal of matching the production of physicians to the needs of the country. According to ABMS, contractual arrangements with HEW, however, may not be the best way of establishing responsibility and securing the means of carrying out that responsibility, and, therefore, alternatives should be considered.

AAMC

AAMC informed us that its executive council had approved the recommendations that the AAMC:

"Support the proposal in the GAO Report that the CCME accept the responsibility for recommending the appropriate distribution of residencies among the specialties of medicine, but not for carrying out or enforcing these recommendations;

"Recommend to the Secretary, DHEW that the Graduate Medical Education National Advisory Council (GMENAC) be abolished when and if the CCME accepts the proposal;

"Recommend that the development of regulatory apparatus be deferred until obviously needed;

"Recommend that, should regulatory apparatus be required, the CCME be invited to participate in its design.

"Recommend that, should regulatory apparatus be required, it be effected by mechanisms that are completely separate from the LCGME accreditation process."

AAMC's position is that CCME should carry out all elements of the program proposed for it in the recommendations in our report except the actual regulatory function. It felt that so long as events continue to evolve in a socially desirable direction as a result of spontaneous and voluntary acts of individuals in the system, additional action should be postponed. Once created, AAMC felt that enforcement mechanisms are seldom abandoned. Therefore, it felt the Nation should put off forming any new regulatory body until a need for it is widely perceived.

AAMC further commented that the draft report was characterized by a pervasive overoptimism about the degree of precision with which "need" can be determined and about the feasibility of regulating the manpower development process to attain any predetermined level of "need." It felt that the regulation/control that would have to be imposed to achieve the objectives sought would affect the continuum of medical education with considerable force. According to AAMC, the draft report failed to explicitly note that the recommended proposal would radically transform the character of the medical education process and probably also the health care delivery system.

AMA

AMA stated it has long recognized that it has a legitimate, proper concern for, and major responsibility to oversee, the quality of medical education and to provide a continuing supply of well-qualified physicians to meet the medical manpower needs of the public. AMA agreed with statements in the draft report that factual information be developed in order that better planning and recommendations may be made for the future. It believes that sound planning for the future medical care delivery to the people of this country should be led primarily by the profession which is chiefly involved and most knowledgeable in this area rather than the Federal Government. AMA told us it will continue to participate, individually and through CCME, in the study of the Nation's needs for medical services, and in the development of strategies by which those needs may be fulfilled.

AMA pointed out that the public's need for physicians' services should first be assessed and the result balanced against presently available and predictable sources of physician services. Any inequities or discrepancies thus revealed could be the subject of recommendations for correction However, according to AMA, this approach does not consider any changes in physician productivity which may occur, and it assumes that physicians function in fixed proportions in the delivery of medical care. AMA also stated it does not consider possible changes in medical technology or public health practice as the result of scientific breakthroughs and, furthermore, it should be recognized that changes in practice rapidly affect changes in needs.

AMA told us that its most serious concern with the draft report is that the included data does not support allegations and recommendations that the present system of physician distribution needs to be changed. According to AMA, the draft report does not establish any deficiencies or flaws in the present system of physician production based on responses by the medical profession to our questions. AMA's contention is that the draft report contains statistical evidence confirming that, although it is somewhat imperfect, the present system functions adequately. It does so through the efforts of the profession in response to perceived needs of the public, without the necessity for legal restriction or direction. Furthermore, imperfections in the present complex system have already been identified and are being addressed.

The AMA believes that regulation of the supply of physicians and their specialties by Government or professional organizations is neither necessary nor wise and would have an unpredictable and detrimental impact on the future quality of health care and, therefore, would not serve the public interest. Instead, AMA believes the public interest can best be served under a system which maximizes the freedom of individuals to choose their own careers under normal competitive conditions. It believes that neither physicians nor other health professionals should be subject to Government or organizational controls as to number and type and pointed out that other occupations are not subject to such controls.

In effect, AMA looks to voluntary action rather than regulation or control of graduate medical education training programs to achieve the desired results once data is developed which identifies physician manpower requirements. Specifically, AMA stated that if the true picture is elicited through complex and thorough analysis of existing and new data, and if these facts are widely publicized to the general public and to all components of the medical profession with appropriate recommendations, it firmly believes that medical students, training program directors, hospital administrators, and medical school deans will react to modify the availability of medical services with resultant improvements in the distribution of medical manpower.

HEW

HEW 1/ told us that it does not agree with our proposal that CCME assume responsibility for developing and implementing a system to see that the number and types of physicians trained are consistent with the approximate number needed. HEW stated that the issues inherent in any analysis of specialty requirements have an immense bearing on the public interest and the value judgments involved in establishing training goals and influencing change, require public participation, an open deliberative forum, and a close relationship to the public policy development process. HEW said that CCME does not fulfill these requirements.

Instead, HEW stated it has already chartered GMENAC which was given responsibility by the Secretary to accomplish most of the objectives sought by GAO and can be expected to do so in a timely manner. GMENAC is to advise the Secretary not only on the best information available on the supply and requirements of physicians by specialty and the establishment of national goals for the distribution of graduate medical education training positions, but most importantly to advise on options as to how the public and private sectors may work synergistically to accomplish those goals. According to HEW,

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1/HEW told us that these comments represent the tentative position of HEW and are subject to reevaluation when the final report is issued.

GMENAC's first report to the Secretary, expected in December 1978, will include recommendations and short- and long-term strategies for effecting needed changes in specialty manpower production.

According to HEW, GMENAC was established to take into account various perspectives, such as those of Federal and State Governments, planners, payers, consumers, students, and osteopathic medicine. Furthermore, because of its operation in a public forum, it is expected that a broad representation of views will be obtained.

In taking this position, however, HEW recognized the need for the medical profession to assist in the analyses which will be necessary for GMENAC to complete its work and, if necessary, to conduct its own analyses, draw its own conclusions, and present its own recommendations. Parallel analytic efforts are viewed by HEW as beneficial from the standpoint of a national debate on such an important topic and, hopefully, varying viewpoints will either be resolved or presented as optional plans for public policy decisionmaking. In HEW's judgment, no single entity has at its command sufficient human, fiscal, or data sources to accomplish singlehandedly the task. HEW stated that the nature of the problem is sufficiently complex, and important, so that many organizations, appropriately, should be examining these issues within the context of their particular mission and constituency in order to foster the most productive and constructive public policy examination of the Nation's need for physician specialists.

It is anticipated that GMENAC will use HEW staff, contracts, and its own expertise in accomplishing its objectives. HEW said that throughout GMENAC's initial period of problem identification and goal setting, cooperation, information exchange, and analytic collaboration with various organizational units within the Federal Government are planned. In addition to the potential contribution of the CCME, HEW will request contributions from the National Academy of Sciences, AAMC, AMA and others.

HEW did not agree with our proposal that a system be developed to adjust the distribution of graduate medical education training positions through the accreditation process. HEW said that our position calls for developing controls and a form of regulation which cannot, at this time, be supported as necessary. HEW stated its position does not, however, exclude a determination at some future time that control or regulation is needed and feasible.

Options as to how the public and private sectors may work to accomplish GMENAC's recommendations are an intrinsic part of the later phases of GMENAC's work. HEW pointed out, however, that recommendations for public policy will be considered largely in the context of how extensive the gap is between the recommended distribution of physician training positions and the projected distribution in the absence of change. To determine the options and the tactics without precisely defining the extent of the problem or the degree and timing of the desired redistribution would limit the creativity of the group and impede the development of innovative solutions which capitalize on public and private sector resources.

HEW's concern is that an orderly process be followed in the examination of the issues, the development of the dimensions of the problem and the study of the forces that are naturally at work in the system to produce physician specialists. Once the goals or targets have been set, an examination of the various strategies that might be adopted to accomplish the goals will be undertaken by GMENAC and HEW.

According to HEW, this examination will include the possibility that regulation is not the only mechanism and/or most appropriate mechanism to effect change. There have been examples of substantial change in the dynamics of specialist manpower production including, for example, the development of a family practice movement, all of which, according to HEW, have been accomplished without resorting to regulation. Furthermore, HEW stated it is possible that the development of a specific set of goals, ranges, and options may, of themselves, bring about all or some of the desired changes in the mix of physician specialists.

Even if regulation of the graduate medical education system should be found necessary at some point in the future, HEW said it would not endorse our proposal that it be implemented through the accreditation process. Accreditation has been established as a means of assuring that all graduate medical education programs meet defined standards of quality. HEW said that the establishment of the Liaison Committee on Graduate Medical Education, which is responsible for accrediting graduate training programs, has been long and difficult. LCGME is in a position to influence positively the actions of a variety of residency review committees which so far have operated in a quasi-independent manner. In HEW's view an attempt to force change in LCGME's function would be counterproductive and would, by mixing functions, distort the quality maintenance effort with considerations of numbers and location in ways that would compromise both efforts.

In the draft report we proposed that HEW determine the number of physician extenders needed in the Nation and CCME consider their impact on the number and types of physicians needed. HEW told us it agrees that projections of demand for physician extender services need to be developed. However, HEW said the examination of the requirements for physician extenders cannot be conducted in isolation from those for physicians, and in this respect, stated GMENAC has already indicated it will consider this matter. HEW pointed out that although physician extenders form a valuable resource for increasing physician productivity, current estimates of requirements are uncertain because of the unpredictability of their use in our current pluralistic system of medical care and the potential changes in reimbursement policies.

HEW agreed with the proposal in our draft report that it continue to emphasize funding those graduate medical training programs leading to the development of additional primary care physicians while the study on manpower requirements is being conducted.

VA

The Administrator of VA stated that after clearance is obtained from the Office of Management and Budget, VA plans to request deletion of its legislative responsibility under Public Law 92-541 for support of both new medical schools and the expansion of existing ones. We were also advised that, at the same time, statutory authority will be sought permitting VA's broader participation in community-based primary care programs and in training allied health personnel supportive of the primary care effort. In addition, VA stated it will also continue to expand internal medicine residency training programs and further support the national consensus for more primary care physicians.

Federal Trade Commission

The Federal Trade Commission's (FTC) Bureaus of Competition and Economics 1/ stated that the report addresses complex social and economic problems and makes recommendations with

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1/Responsibility for responding to our draft report was delegated by FTC to its Bureaus of Competition and Economics. Because FTC has administrative litigation pending before it involving AMA, which is a member of CCME, FTC stated it has neither expressed any views regarding the report nor adopted the Bureaus' views.

serious consequences without, however, analyzing critical assumptions and issues. They believe strong recommendations for drastic action should not be issued without substantial further analysis, and the report, therefore, should go no further than recommending a detailed study of the Nation's health needs.

The Bureaus said that the report failed to define "national needs" and to elaborate on how that term would apply to the total number of physicians, to the overall physician supply by specialty, or to overall and specialty physician supply by geographic area, which makes it impossible to determine the extent of physician supply imbalances in any of these categories.

They stated that any single measure of "need" may be impossible to implement because conditions may well change during the long lead time between identifying a distortion and choosing and enacting its solution. Second, previous attempts to define national health manpower needs have reached significantly different conclusions, a result which indicates that any single measure of need and optimal physician supply may be impossible to devise and implement. Therefore, the Bureaus believe more defensible approaches should be considered.

According to the Bureaus, proposals in the draft to give CCME responsibility for either conducting a study of health needs or actually determining the number and types of the Nation's physicians and physician extenders raise serious conflict of interest issues. They pointed out that

--CCME is a private organization, dominated by professional societies of physicians which, in addition to performing certain education and scientific functions, act as trade associations advancing the economic and other interests of their members.

--Members of CCME's constituent organizations have an economic interest in the number and specialties of new, competing physicians who will enter medical practice.

--By virtue of its membership of representatives from professional organizations, CCME would have a conflict of interest in performing the work recommended in our report.

--Apart from this organizational bias, CCME can take no action, without approval of each of its sponsors, which could present an opportunity for its members to abuse CCME's role to protect their narrow interests.

--Because CCME is not fully representative of all of the interests in the health care services likely to be affected by its decisions, CCME might not adequately address all of the issues necessary to its determinations.

The Bureaus consider it a drastic approach to use the accreditation process as the implementing mechanism for affecting changes required in the number and types of physicians trained and stated it would have been appropriate to consider milder and more flexible methods. In particular, the Bureaus said the report should have considered the variety of incentives and disincentives available to the Government to influence private action as alternatives to tampering directly with the accreditation mechanism.

In conclusion, the Bureaus recommend that the Nation's medical needs should be further studied. However, they believe that such a study should not be performed by persons likely to have real or apparent conflicts of interest or preexisting biases and, therefore, the recommendation that a study be undertaken should omit reference to CCME. The Bureaus did not suggest that medical organizations have no role in preparing the study since they clearly recognize that their insights are necessary and valuable. They believe CCME ought to be able to comment on proposed action along with other interested groups.

DOD

The Department of Defense said it had no comments on the draft report.

OUR POSITION

Prior to the date of our draft report, the CCME had not taken a position on whether it should become involved in determining an appropriate mix of physicians for the Nation.

Comments by CCME and the constituent members on our draft report now indicate a willingness to accept responsibility for determining the physician manpower needs of the Nation on a specialty by specialty basis but a reluctance to use the accreditation process in graduate medical education as a basis for controlling either numbers or kinds of specialty training programs. CCME's comment on this was very clear in that it felt the goal of matching ongoing production of physicians to the changing needs of the country for medical care should be attempted without the difficulties and implications involved in regulation, either by the Government or by any organization in the private sector.

HEW was opposed to our proposal that a system be developed to adjust the distribution of graduate training positions through the accreditation process. HEW said this position calls for the development of controls and a form of regulation which cannot, at this time, be supported as necessary. HEW's position, however, did not exclude a determination at some future time that control or regulation is needed and feasible. Even if regulation should be found necessary in the future, HEW said it would not endorse our proposal that it be implemented through the accreditation process.

FTC's Bureaus of Competition and Economics consider it a drastic approach to use the accreditation process as the implementing mechanism for effecting changes required in the number and types of physicians trained. Instead, FTC looks to the variety of incentives and disincentives available to the Government to influence public action.

As a result of these comments, we are modifying our proposal in the draft report that CCME should have responsibility for periodically "taking steps necessary through its liaison accreditation committee structure to see, after consulting with the Secretary of HEW, that the number and type of physicians in graduate medical education training positions are consistent with national needs." Instead, we now believe the medical profession, through CCME, should be allowed to demonstrate that it can accomplish this important step by other available means.

HEW did not agree that CCME should study the Nation's medical care needs. Instead, HEW looks to its advisory committee to do the study. HEW stated that the issues inherent in any analysis of specialty requirements have an immense bearing on the public interest and the value judgment involved require public participation, an open deliberative forum, and a close relationship to the public policy development process. HEW said CCME does not fulfill these requirements. On the other hand, GMENAC was established to take into account various perspectives and, by virtue of its operation in a public forum, HEW expects that a broad representation of views will be obtained.

FTC's Bureaus of Competiton and Economics were also opposed to having CCME responsible for either conducting a study of health needs or actually determining the number and types of the Nation's physicians and physician extenders. They prefer to have such tasks performed by individuals who are not likely to have any real or apparent conflicts of interest or preexisting biases.

Because of the number of organizations which make up the CCME, the intimate knowledge its members have of the health care system, data it has ready access to, and the vital interest in the way in which health care is delivered, we still believe CCME is in the best position to study the Nation's needs for various kinds of physicians and physician extenders. We recognize the concern about additional perspectives and the possible conflict of interest. We believe these concerns could be overcome if HEW's GMENAC were to (1) play an active role in determining the scope of these studies and in monitoring their progress and (2) review indepth CCME's completed studies and provide the Secretary with its detailed comments and recommendations. To deny the CCME and, in effect, the medical professions the opportunity to actively participate in any such studies would be tantamount to ignoring the most knowledgeable persons and the best evidence in existence on this subject. Any studies made without their active participation would, in our opinion, suffer in credibility, be subjected to strong criticism and opposition, and be difficult to implement.

If satisfactory progress has not been made in determining the need for each of the various physician specialties and developing appropriate types of specialists after some reasonable period of time, then HEW should take more forceful and direct action to see this is accomplished.

We recognize that the public interest can be served under a system which maximizes the freedom of individuals to choose their own careers and that voluntary action rather than control or regulation by an organization or entity over graduate medical education training programs, is one method of achieving the desired results once data is developed which identifies physician manpower requirements. However, in our view, even under a voluntary approach, it will still be necessary for some organization or entity to monitor actions being taken to bring about adjustments in the size, number, and distribution of graduate medical education training programs and positions. We believe this is a proper role for HEW since the President has already given it primary responsibility for implementing the national health strategy.

RECOMMENDATIONS TO THE SECRETARY, HEW AND ADMINISTRATOR, VA

We recommend that the Secretary of HEW direct its Graduate Medical Education National Advisory Committee to work with the CCME in determining the number and type of physicians and physician extenders needed in the Nation. In this regard we recommend that the Secretary or his designee meet with representatives of the CCME to explore its engaging in national studies of physician and physician extender manpower supply and requirements under some mutually agreeable contractual arrangement. GMENAC should play an active role in determining the scope of these studies and monitoring their progress. Moreover, on completion of these studies GMENAC should review them indepth and provide the Secretary with its detailed comments and recommendaitons.

At a minimum, these studies should involve the collection and analysis of the following types of data: morbidity and mortality information; number and type of patients seeking physician care in various specialties; number, ages, and geographic location of practicing physicians by specialty and subspecialty; numbers and types of procedures actually performed by physicians in various subspecialties; the ways various specialists interrelate; number of physician extenders and other types of paraprofessionals entering the medical field and the duties they perform; likely imminent changes in the various specialties because of technological breakthroughs; and reimbursement mechanisms, possible changes thereto, and their impact on physician specialty choices.

On completion of these studies, we recommend that HEW and the CCME attempt to reach some mutual agreement on approximate manpower supply and requirements in order to provide a reasonably accurate assessment of the Nation's present and future need for the various types of physicians and physician extenders, including establishment of recommendations to achieve desired goals.

We further recommend that

--HEW publish the results of these analyses and make them available to appropriate congressional committees, the general public, and all components of the medical profession.

--Where imbalances are determined to exist, HEW encourage medical schools and teaching hospitals to make appropriate adjustments in the size of their residency training programs.

--HEW, through its GMENAC, monitor the voluntary efforts by the medical profession to achieve the desired goals.

If voluntary actions by the medical profession do not achieve the desired results of eliminating any imbalances determined to exist in graduate medical training programs and positions, within a reasonable period, then HEW should seek appropriate legislative action.

While these studies are being conducted, we recommend that the Secretary of HEW continue to emphasize funding those graduate medical education training programs leading to the development of additional numbers of primary care physicians. We also recommended that the Administrator of Veterans Affairs continue to emphasize general internal medicine training.

RECOMMENDATIONS TO THE CONGRESS

Determining the appropriate number of physicians needed in the United States by specialty and in aggregate is not an easy task. As previously explained, many factors must be considered. Much data still needs to be collected and analyzed. The Congress can aid in this process by working with the President to develop a clear national health policy. Programs which offer services to consumers in maternal and child health clinics, kidney dialysis units, alcohol or drug programs, etc., all have an impact on health manpower requirements. The enactment of a national health insurance program similarly would have an impact on health manpower needs, depending on the extent and type of coverage provided. To the extent that the Congress and President can clearly articulate their intent to develop and support health programs and the kind of support to be provided, manpower projections will be somewhat easier.

When HEW and CCME have developed a reasonably accurate assessment of the approximate number of physicians required in each specialty and subspecialty to meet national needs, have compared this assessment with the number currently in practice and in training, they will be able to estimate the number of first-year graduate medical education training positions required. This number will constitute the total number of first-year graduate training positions needed in the Nation.

Should the total number of first-year graduate training positions needed be greater than the number available in medical schools in the United States, we recommend that the Congress consider whether

--additional medical schools should be established or the capacity of existing medical schools should be increased or

--the shortage should be filled by U.S. citizens studying abroad or by foreign medical graduates.

On the other hand, should the total number of needed first-year graduate medical education training positions be less than the number available, we recommend that the Congress explore the extent to which Federal financial assistance designed to increase the number of medical school graduates is necessary and should be continued.

Furthermore, until the overall need for additional physicians is more precisely determined, we recommend that the Congress explore whether it wants VA to continue providing Federal grants either to establish new medical schools or increase the capacity of existing ones, as provided under Public Law 92-541.

ORGANIZATIONS INVOLVED IN GRADUATE MEDICAL EDUCATION

RESIDENCY REVIEW COMMITTEES

These committees are responsible for the substantive review and evaluation of graduate medical education training programs. They ascertain that sufficient instructors, patients, and facilities are available to provide adequate training. The objective of residency review committees is to continually improve the quality of graduate medical education.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges is now composed of representatives from 114 academic medical centers, 400 teaching hospitals, and 60 academic societies. These are the principal institutions and organizations responsible for educating physicians from the time they enter medical school until they leave their formal training and assume professional roles in the health care system.

AMERICAN BOARD OF MEDICAL SPECIALTIES

The American Board of Medical Specialties is a coordinating board for its members which include 20 primary boards, 2 combined boards, and 5 associate members. Its scope of activities is related almost exclusively to those elements which are important in evaluating and certifying physicians who apply for recognition as specialists in an area represented by member boards.

COUNCIL OF MEDICAL SPECIALTY SOCIETIES

The Council of Medical Specialty Societies consists of 20 medical organizations which provide a forum for discussing problems of national and mutual interest to the medical specialties, and to initiate studies and discussion of problems of national importance confronting American medicine. To foster excellence in medical education and improve the quality of medical care in the United States, it established, among other things, an objective to monitor and make recommendations to appropriate organizations on optimal policies regarding numbers and distribution of medical personnel.

AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association comprises more than 29,000 hospitals and individuals. Its objective is to promote the public welfare through developing better hospital care for all the people. Historically, it has been concerned with graduate medical education in its desire to establish objective standards for hospital appointments.

AMERICAN MEDICAL ASSOCIATION

The American Medical Association has 172,000 physicians in good standing in 55 State associations. Among other things, it provides information to members on national and State medical and health legislation, represents the profession to the Congress and Government agencies, and cooperates in setting standards for medical schools and graduate medical education training programs.

PHYSICIAN SPECIALTY BOARDS

The primary objectives of specialty boards is to improve the quality of medical education and care by assuring the competence of candidates who appear for examinations and certifying those who are qualified.

PHYSICIAN SPECIALTY SOCIETIES

Specialty societies are usually recognized as the spokesperson organizations for practicing specialists and are concerned with the competence and welfare of the clinical specialist.

APPENDIX II

APPENDIX II

Optimal Physician to Population Ratios

According to Medical Professional Organizations

Specialty	Specialty societies			Specialty board			Residency review committees		
	Optimal ratio	No opinion	No reply	Optimal ratio	No opinion	No reply	Optimal ratio	No opinion	No reply
Allergy and immunology			(a)		X			X	
Anesthesiology		X			X			b/X	
Colon and rectal surgery	1:100,000			1:100,000				b/X	
Dermatology	3.2:100,000			3.2-3.4:100,000				b/X	
Family and general practice:									
Family practice	1:2,500					X	1:2,500		
General practice								X	
Internal medicine		X			X			X	
Neurology and psychiatry:									
Neurology (note c)									
Psychiatry	1:25,000				b/X			b/X	
Neurological surgery		X			X			X	
Nuclear medicine			(a)		X			X	
Obstetrics/Gynecology	1:10,000				X			X	
Ophthalmology and Otolaryngology:									
Ophthalmology		X			X			b/X	
Otolaryngology		X		2.5-3.5:100,000				X	
Orthopedic surgery		X			X			X	
Pathology		X			X			b/X	
Pediatrics	1:2,000-2,500				b/X			b/X	
Physical medicine and rehabilitation	1:50,000				X			b/X	
Plastic surgery				1:50,000			1:50,000		
Preventive medicine		X				X		b/X	
Radiology		X			b/X			X	
Surgery		X			b/X			b/X	
Thoracic surgery	1:100,000			1:100,000				b/X	
Urology	1.67-4:100,000	—	-	1:10,000	--	-	———	X	-
Total	9	10	1	6	14	2	2	21	0

a/We contacted those societies which are members of the Council of Medical Specialty Societies. Allergy and Immunology and Nuclear Medicine are not members.

b/These organizations specifically advised us that manpower issues are not within their purview.

c/Neurology and psychiatry have a combined residency review committee.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. [illegible]

NOV 7 1977

Mr. Gregory J. Ahart
Director, Human Resources
  Division
United States General
  Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Problems in Training an Appropriate Mix of Physician Specialists." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

DEPARTMENT COMMENTS TO GAO DRAFT REPORT ENTITLED, "PROBLEMS IN TRAINING AN APPROPRIATE MIX OF PHYSICIAN SPECIALISTS"

GENERAL COMMENTS

Perhaps the most fundamental observation to be gleaned from the report is that the wide diversity of viewpoints (except as related to the need for additional primary care physicians) and an apparent lack of definitive information about physician specialty requirements point up the embryonic stage of development of physician manpower analysis. While the report utilizes and reflects professional judgment extensively, it frequently omits reference to the complexity of the issue of estimating physician requirements and does not emphasize that various alternative mixes of physician specialists may be able to provide the health services needed and desired in this country. In other words, a single optimal distribution may not be appropriate.

Physician specialty requirements cannot be isolated from several major considerations, such as the overlapping functions provided by different types of specialists, the diverse ways that health care is organized, the utilization of nonphysician manpower, geographic distribution, the quality of care and the cost of health care. Forecasts of future requirements are further complicated by demographic changes, modifications in consumer expectations, demand shifts occasioned by changes in cost and/or health care financing, changes in the prevalence of disease or disability, and technological developments. Likewise, estimates of the future supply of physicians require predictions of the impact of changes in public policy in regard to the support of medical education, the influx of foreign medical graduates, and so forth.

The following comments on the draft report are provided in this context:

GAO RECOMMENDATION

The Secretary of HEW should meet with representatives of the Coordinating Council on Medical Education and determine whether they would be willing to assume responsibility, under a contract with HEW, for developing and implementing a system for seeing that the number and types of physicians being trained is consistent with the approximate number needed. Under the contract, the CCME should have responsibility for periodically:

1. developing optimal physician to population ratios for each physician specialty and subspecialty, taking into consideration the interrelationships among the various specialties that exist and that many physicians do not practice solely in the specialty in which they received their graduate medical education;

2. comparing these ratios with physician to population ratios of those in practice and in training, taking into consideration such factors as attrition as a result of death and retirement and the number of non-practicing physicians, and based upon this assessment;

3. taking steps necessary through its liaison accreditation committee structure to see, after consulting with the Secretary of HEW, that the number and type of physicians in graduate medical education training programs are consistent with national needs.

If the CCME does not choose to accept the role, outlined above, then the Secretary of HEW should assume this responsibility. If additional authority proves warranted to perform these steps or if adjustments in the number and type of physicians being trained are necessary to meet national needs based on HEW's analysis, we recommend that the Secretary of HEW determine what specific additional authority it needs to accomplish these tasks and submit appropriate recommendations to the Congress.

DEPARTMENT COMMENT

We do not concur with the principal thrust of the GAO's recommendation i.e., that the CCME assume responsibility for developing and implementing a system to see that the number and types of physicians being trained are consistent with the approximate number needed. The issues inherent in any analysis of specialty requirements have an immense bearing on the public interest. The value judgments required in establishing training goals and influencing change require public participation, an open deliberative forum, and a close relationship to the public policy development process. The CCME does not fulfill these requirements.

The Department has chartered the Graduate Medical Education National Advisory Committee (GMENAC) under authority granted to the Secretary in the Public Health Service Act. This twenty-one member body is to advise the Secretary not only on the best information available on the supply and requirements of physicians by specialty and the establishment of national goals for the distribution of graduate medical education positions, but most importantly to advise on options as to the means by which the public and private sectors may work synergistically to accomplish those goals.

The Committee has been established to take into account various perspectives, such as those of Federal and State governments, planners, payers, consumers, students, and osteopathic medicine. Furthermore, by virtue of its operation in a public forum, it is expected that a broad representation of views will be obtained.

To be more specific, GMENAC's charter charges the committee to analyze and develop future strategies, to analyze the present and future supply and requirements for physicians by specialty and geographic location, and to translate these requirements into a range of the types and numbers of graduate training opportunities needed to approach a more desirable distribution of physician services. The committee is further charged to develop such goals and strategies in the context of the multiple factors which affect the health care system, including reimbursement and health planning.

GMENAC's first report to the Secretary, expected in December of 1978, will include recommendations and short- and longer-term strategies for effecting changes in specialty manpower production that are needed.

The Department, therefore, does not disagree with the context of the desired outcomes which the General Accounting Office had in mind with respect to points one and two of its initial and principal recommendation. GMENAC has been established to accomplish them and can be expected to do so in a timely manner. Concurrently, however, the Department recognizes the need for the profession to assist in the analyses which will be necessary for GMENAC to complete its work and, if necessary, to conduct its own analyses, draw its own conclusions, and present its own recommendations. Parallel analytic efforts are viewed as beneficial from the standpoint of a national debate on such an important topic. Hopefully, varying viewpoints will be either resolved or presented as optional plans for public policy decisionmaking.

It is anticipated that GMENAC will utilize HEW staff, contracts, and its own expertise in accomplishing its objectives which include ranges of specialist-to-population ratios such as those recommended in the GAO report. Throughout GMENAC's initial period of problem identification and goal setting, cooperation, information exchange, and analytic collaboration with a variety of organizational units within the Federal Government are planned. In addition to the potential contribution of the CCME, contributions from the National Academy of Sciences, the Association of American Medical Colleges, the American Medical Association, etc., will be requested. In our judgment, no single organizational entity has at its command sufficient human, fiscal, or data sources to singlehandedly accomplish the task at hand. The nature of the problem is sufficiently complex, and important, so that many organizations, appropriately, should be examining the issues within the context of their particular mission and constituency in order to foster the most productive and constructive public policy examination of the Nation's need for physician specialists.

Options as to how the public and private sectors may work to accomplish GMENAC's recommendations are an intrinsic part of the later phases of GMENAC's work. However, it must be kept in mind that the recommendations for public policy will be considered largely in the context of how extensive the gap is between the recommended distribution of physician training opportunities and the projected distribution in the absence of change. To determine the options and the tactics without precisely defining the extent of the problem or the degree and timing of the desired redistribution would limit the creativity of the group and impede the development of innovative solutions which capitalize on public and private sector resources. Clearly, points of influence will be considered, including the CCME and its individual constituent organizations, the policies and procedures for third party reimbursement, State Health Planning and Development Agencies, Health System Agencies, State agencies which oversee the allocation of State resources for medical education, licensure systems, etc.

The Department does not agree with the third point of the recommendation that a system should be implemented which would adjust the distribution of graduate medical education positions through the accreditation process. The GAO specifically calls for the liaison accreditation committee "to see" that the numbers of specialist physicians being trained are consistent with national needs. This position clearly calls for the development of controls and a form of regulation which cannot, at this time, be supported as necessary. Regulation of training positions by institution and by specialty will not be feasible in the immediate future.

This position does not exclude a determination at some future time that control or regulation is needed and feasible. Our concern is that an orderly process be followed in the examination of the issues, the development of the dimensions of the problem and the study of the forces that are naturally at work in the system to produce physician specialists. Once goals or targets have been set, an examination of the various strategies that might be adopted to accomplish the goals will be undertaken by GMENAC and the Department. This examination would include the possibility that regulation is not the only mechanism and/or the most appropriate mechanism to effect change. There have been examples of substantial change occurring in the dynamics of specialist manpower production including the development of the Family Practice movement, the expansion of psychiatric training, the development of needed research manpower, all of which have been accomplished without resorting to regulation. Furthermore, it is possible that the development of a specific set of goals, ranges, and options may, of themselves, bring about all or some of the desired changes in the mix of physician specialists.

Even if regulation of the graduate medical education system should be found necessary at some time in the future, the Department would not endorse the GAO's implication that it be implemented through the accreditation process. Accreditation has been established as a means of assuring that all graduate medical education programs meet defined standards of quality. While there is some degree of variation in the quality of these programs, and a few could be singled out as being of extraordinarily high quality, the rest have been determined, according to established criteria, to be acceptable.

The development of the Liaison Committee on Graduate Medical Education has been long and difficult. It is in a position to influence positively the actions of a variety of residency review committees which hitherto had operated in a quasi-independent manner. Currently, a major review of the general criteria for residency program accreditation is being undertaken with a view toward the strengthening of the review process, the application of standards, and the development of increased degrees of institutional accountability. It is our view that to attempt to force a change in function would be counterproductive, and would, through the mixing of functions, distort the quality maintenance effort with considerations of numbers and location in ways that would compromise both efforts.

GAO RECOMMENDATION

GAO also recommends that the Secretary of HEW determine the number of physician extenders needed in the Nation and the Coordinating Council on Medical Education take into consideration their impact on the number and type of physicians needed.

DEPARTMENT COMMENT

It must be recognized that although such physician assistants and nurse practitioners form a valuable resource for increasing physician productivity, current estimates of requirements are uncertain because of the unpredictability of their utilization in our current pluralistic system of medical care and potential changes in reimbursement policies.

We agree that further analysis of the issues associated with the role and function of the physician extender needs to be accomplished and, in particular, that projections of demand for their services in the system need to be developed using various assumptions. However, the examination of the requirements for physician extenders cannot be conducted in isolation from those for physicians, and in this respect the Graduate Medical Education National Advisory Committee has already indicated it will take this matter under consideration. Substantial research and analysis of physician extender issues have been undertaken in recent years and some initial estimates have been developed with respect to employment demand. The Health Resources Administration plans a thorough review of the completed research and, through analytic efforts, to resolve unanswered questions in order to proceed with the development of data which should be useful in deriving a first approximation of the numbers of physician extenders that can effectively be deployed. These data, and the value judgments of GMENAC, will be helpful in developing the options for future physician supply.

GAO RECOMMENDATION

During the interim period while the above study is being conducted, the Secretary of HEW should continue to place emphasis on funding those graduate medical education training programs leading to the development of additional primary care physicians.

DEPARTMENT COMMENT

We concur with this recommendation. The Department had provided support to, and will continue to assist in the development and operation of, family practice residencies. A new program of support for the development of general internal medicine and general pediatric specialty training will also be continued. These efforts have increased the supply of primary care specialists. It is anticipated that continued support will be available.

GAO Note: HEW's technical comments were incorporated in the report where appropriate.

FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

AUG 23 1977

Mr. Gregory J. Ahart
Director, Human Resources Division
United States General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Ahart:

The General Accounting Office has requested comment by the Federal Trade Commission on a draft of a report to Congress entitled "Problems in Training an Appropriate Mix of Physician Specialists" (hereinafter "report"). The Commission has delegated responsibility for responding to GAO's request to the Bureaus of Competition and Economics (hereinafter the "Bureaus"). */ We set forth in this letter

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*/ The Bureau of Competition is one of two litigating units of the Federal Trade Commission and is charged with enforcing the policies of the antitrust laws. The Bureau of Economics is separate from the litigating Bureaus and is charged, among other things, with providing independent economic advice to the litigating Bureaus, and with studying the economic characteristics of American industry.

At present, the Bureaus are investigating competition in the health care industries, including professional health care services. The Bureau of Competition has submitted to the United States Office of Education its views about continued recognition of the Liaison Committee on Medical Education as the accrediting agency for medical schools, and it has submitted to the Division of Health Manpower of the United States Department of Health, Education and Welfare its views about recognition of the Liaison Committee on Graduate Medical Education as the accrediting agency for medical residency programs.

Although the Commission has authorized the Bureaus to transmit their views on the matters dealt with in this letter, it has neither adopted those views nor otherwise expressed any views regarding the report because it has pending before it administrative litigation (Docket 9064) involving the American Medical Association, which is one of five sponsors of the Coordinating Council on Medical Education.

our views regarding these matters and request that our comments be given consideration by your office before it makes any final recommendations. */

GAO's report proceeds from the joint assumptions that there exists an excessive supply of physicians and a maldistribution of physicians in various medical specialties, and that an organization must have responsibility for regulating physician supply. From a poll of opinion based on these assumptions, the report recommends that the Secretary of Health, Education and Welfare contract with the Coordinating Council on Medical Education (CCME) to determine the number and area of specialty of physicians and related allied health personnel "needed" by the nation and to ensure that the numbers of people in training are consistent with the perceived needs. It also recommends that CCME implement this program through its oversight of the accreditation activities of the Liaison Committee on Graduate Medical Education ("LCGME"), which accredits residency programs. The report, however, contains neither an explanation of the origin of its basic assumptions nor an analysis of their validity. This is a serious deficiency, for the issues are both complex and controversial. In addition, the recommendation that CCME be assigned responsibility for rationalizing physician supply raises serious conflict of interest problems. The report contains no analysis of the conflict issues and in fact reaches its conclusions upon uncritical acceptance of opinions given by the physician groups with the greatest economic interest in the outcome.

Initially, the report assumes that there is a "national need" for physician services which can be accurately measured and to which a supply of physicians can be matched. It does not, however, define "national need," a term which is ambiguous without further explanation. The term may refer either to some absolute measure of the good health of the population as indicated by measures of mortality and morbidity, or it may mean the demand for physician services.

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*/ The request for comments included a request for an opinion on the legality, under the Federal Trade Commission Act, of the HEW contract recommended in the report. As suggested in the text of this letter, however, there are numerous economic issues which would have to be analyzed before the competitive impact, and hence legality, of the suggested HEW contract could be assessed. Furthermore, the recommendations are in general terms, whereas a legal opinion would require an analysis of the actual contract which HEW would propose, the law under which it would be made, and perhaps the legislative history of that law. Unfortunately, therefore, we are not able to supply a formal opinion at this time.

The analysis implied by the former meaning obviously is a complex task involving many subjective judgments; in fact, there appears to date to be no substantial evidence that the supply of physicians, at least within fairly wide ranges, has a significant effect on mortality or morbidity. "Need" for physician care also, and more commonly, may be taken as a reference to the sum of individual demands for physician services. This meaning of "need" raises less obvious, but equally difficult, problems of measurement, for there is substantial support for the observation that the supply of physicians itself affects the demand for physician services. */ If this observation is even partially accurate, and the weight of opinion appears to be that it is, **/ then the "need" postulated by the report as a measure for supply would be unstable, and consequently unreliable. Furthermore, this problem would become acute if, as recommended in the report, physician groups were to be used to identify the national need for physician care. In that situation, a major input would be the economic judgments of the persons supplying the services rather than an objective, accountable measure of physician need.

Ultimately, it may not be feasible to assume that there is any absolute indicium of "national need." Although there are indicia of "need" relative to various social goals of resource allocation, equity, happiness, physical survival, and undoubtedly many others, the goals must be identified before methods of achieving them can be analyzed. The report omits this essential step. Thus its failure to define "national needs" and to elaborate the manner in which that term would apply to the total number of physicians, to the overall physician supply by specialty, or to overall and specialty physician supply by geographic area makes it impossible to determine the extent to which there may be physician supply imbalances in any of these categories.

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*/ E.g., Reinhardt, Physician Productivity and the Demand For Health Manpower (1975); Fuchs and Kramer, Determinants of Expenditures For Physician Services in the United States 1948-68 (1972). See also, Huang and Shomo, Assessment and Evaluation of the Impact of Archetypal National Health Insurance Plans on U.S. Health Manpower Requirements, report pursuant to Contract No. NIH-72-4404 (1974).

**/ The matter is not uncontroversial. See, contra, Sloan and Lorant, "The allocation of physicians' services: Evidence on Length-of-Visit," 16 Quarterly Rev. Bus. & Stat. 85-103 (Autumn 1976).

Furthermore, without a definition of national need, the results of the interviews conducted by the GAO staff and discussed in the report cannot be assessed, and other data relating to optimal physician-population ratios (for example, comparison of statistics among different countries) cannot be put in perspective.

Implicit in the report's assumption that there is a specific determinable "need" for medical services is the further assumption that there exists one single measure of need. Even if the basic assumption were valid, this further assumption raises several issues which are not fully analyzed in the report. First, the effort to measure future "need" requires that the future be forecast, which always involves uncertainty, for changes in conditions that were the bases of the estimates of needed manpower would render the target numbers inadequate. This is especially true in the case of physician training, which from beginning to end consumes at least seven years. Thus, any single measure of "need" may be impossible to implement because conditions may well change during the long lead time between identifying a distortion and choosing and enacting its solution. Second, previous attempts--discussed in the report--to define national health manpower needs have reached significantly different conclusions, a result which indicates that a single measure of optimal physician supply may be impossible to devise. For these reasons, the report might well have discussed other, more defensible approaches, for example, setting a range for a complex of physician supply targets relating to a variety of social goals.

The method recommended by the report for determining future "national need" also is inadequate because it ignores the demand side--the medical consumer. Because the suggested method would focus on the opinions of current specialty providers, it may be that it would not fully consider the preferences of the general population with regard to matters involving incremental cost of health care compared to improvements in the health of the population. It may also be that it would not fully consider the functional overlap between physician specialties and between physicians and physician extenders. But failure to consider such overlap could itself result in supply imbalances or in a misallocation of resources, especially since physician extenders may be capable of performing some functions traditionally performed by physicians. */

The report also recommends only one means of implementing a determination of the "appropriate" physician supply--to intervene in the accreditation process. Before recommending such a drastic approach, however, it would have been appropriate to consider milder and more flexible methods. In particular, the report should have considered the variety of incentives and disincentives available to the government to influence private action as alternatives to tampering directly with the accreditation mechanism. For example, the report notes that governmental incentives are aiding in alleviating a perceived shortage of primary care physicians; perhaps these incentives could be expanded. It may also be that the cheapest and least disruptive way to alter physician mix would be to retrain some existing physicians.

Thus, the report addresses complex social and economic problems and makes recommendations having serious consequences without, however, analyzing critical assumptions and issues. Upon examination of some of these matters, it would appear that they are not easily resolved and in some cases are controversial. Strong recommendations for drastic action, we believe, should not be issued without substantial further analysis. The report, therefore, should go no further than the recommendation of a detailed study of the nation's health needs.

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*/ There are also important questions about the proposed scope of the coordinating group that would have to be resolved. Should it be allowed to impact state government rules of physician specialty delineations if differences exist? Should it deal with the supply of competing medical service providers such as physician extenders? Should it have central licensing and accreditation authority? How closely should it coordinate with authorities in other areas of medical care? Does coordination offer any potential reduction in overall medical care costs? While the report mentions a few of these matters, it does not discuss any of them adequately.

The report recommends that CCME be contracted by HEW to conduct such a study of health needs and, further, that CCME actually determine the numbers and types of the nation's physicians and related health professions. The selection of CCME for either of these functions, however, would raise serious conflict of interest issues. Attempts to rationalize the supply of physicians would have an economic impact on individual physicians as well as on the economy as a whole. They also, as noted above, involve many complex subjective judgments. Such tasks should be performed, if at all, by persons not likely to have any real or apparent conflicts of interest or preexisting biases. The recommendation of a study, therefore, should omit reference to CCME.

CCME is a private organization, dominated by professional societies of physicians which, in addition to performing certain educational and scientific functions, act as trade associations advancing the economic and other interests of their members. CCME is composed of three representatives from each of its five sponsoring organizations--the American Hospital Association, the American Board of Medical Specialties, the Council of Medical Specialty Societies, the Association of American Medical Colleges and the American Medical Association--of one public representative (selected by the other representatives), and of one governmental representative. The members of these organizations have an economic interest in the number and specialties of new, competing physicians who will enter medical practice. Thus, by virtue of its membership of representatives from professional organizations, CCME would have a conflict of interest in performing the work recommended by the report. Apart from this organizational bias, CCME can take no action without the approval of each of its sponsors, which could present an opportunity for its members to abuse CCME's role to protect their narrow interests. Finally, because CCME is not fully representative of all of the interests in health care services likely to be affected by its decisions, it might not adequately address all of the issues necessary to its determinations.

This conflict of interest would color the recommended process with an "appearance of impropriety" unbecoming to an organization charged with an important governmental function involving subjective judgment. The problem is apparent: in the program recommended by the report, representatives of trade groups would be determining the number and type of their competitors. Regardless of their motives, their actions would always be suspect, for the public could never be sure that the veto power which the sponsors have over the proposed actions of CCME had not been used indirectly to ensure that the interests of their members were not protected to the detriment of the public interest.

CCME's organizational makeup also may produce a distorted view of the nation's "needs". CCME does not include members who are likely to represent fairly the views of divergent elements in health care, for example, students, residents, or prepaid group practices, even though these groups would have legitimate concerns about CCME's recommendations. More significantly, CCME fails to represent the allied health professions, even though the report recommends that it determine also the numbers and mix of physician extenders. The opinions of allied health practitioners and educators about the appropriate scope of their practice may differ from those of physicians or hospital personnel. Those opinions take on still greater significance since the extent of the role of physician extenders directly affects the number of physician specialists needed. Also, CCME does not provide for any significant public or governmental representation and thus might not take into account the overriding public interest in determining health care priorities, reducing health care expenditures, allocating scarce resources, or implementing social policies such as improving care to particular population groups. */ Thus, because of CCME's

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*/ Questions of this sort include, for example: how long should patients have to wait to see a doctor, or for voluntary surgery? How far should patients have to travel to see a subspecialist? Should patients see a doctor in the first instance for routine, typical complaints or should they be treated by physician extenders?

makeup, it would be likely to focus on the opinions of only one segment of current medical specialists */ in arriving at its decisions on national needs.

In conclusion, the report should omit recommendations that the supply of specialty physicians be removed from the operation of the market and that CCME be designated as the agency to determine the nation's medical manpower needs. Instead, we recommend that this report be limited to suggesting that the nation's health needs should be further studied and that such a study be carried out by an organization without an interest in the outcome of that study.

Thank you for the opportunity to express these views. We would be willing to meet with you or members of your staff to discuss this matter further.

Sincerely,

Alfred F. Dougherty, Jr.
Director
Bureau of Competition

Darius W. Gaskins

Darius W. Gaskins
Director
Bureau of Economics

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*/ We do not suggest that medical professionals should not have a role in preparing a study such as the one recommended by the report. Clearly their insights are necessary and valuable, and CCME ought to be able to comment on proposed action along with any other interested groups. Nor do we suggest that no private organization should perform the function recommended by the report. We recommend only that the report be done, if it is necessary, by a group that does not have an inherent financial interest in the outcome of its deliberations.

VETERANS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D.C. 20420

JULY 8 - 1977

Mr. Gregory J. Ahart
Director, Human Resources Division
U.S. General Accounting Office
441 G Street, N.W., Room 6864
Washington, DC 20548

Dear Mr. Ahart:

Your draft report to the Congress, "Problems in Training an Appropriate Mix of Physician Specialists," B-164031(3), was transmitted on April 25, 1977, and I am pleased to offer our comments.

This report focuses on the present national trend in educating health professionals and we basically agree with the findings and conclusions. We believe, through the Veterans Administration (VA) residency programs' affiliation with university programs, there is a high degree of coordination between the VA effort and that in the private sector.

The Veterans Health Care Expansion Act of 1973 gave VA the responsibility for assisting in providing an adequate supply of health manpower to meet national needs. In the absence of national guidelines for the total numbers of physicians needed and the appropriate mixes by specialty and other categories, a consensus of need has emerged. In response, the VA moved to assist in increasing the number of medical school positions, increasing the numbers of positions in internal medicine, decreasing proportional support of residency positions in surgery and its subspecialties, and decreasing the number of residency positions occupied by foreign medical graduates at a rate greater than the nation at large. Therefore, in seeking continuation of the authorities in P.L. 92-541, the VA, after obtaining clearance from the Office of Management and Budget, will request legislative changes concerning creation of new medical schools and the expansion of positions in existing schools.

GAO Note: Deleted comments refer to material contained in the draft report which was revised in the final report.

Mr. Gregory J. Ahart
Director, Human Resources Division
U.S. General Accounting Office

GAO Note: Deleted comments refer to material contained in the draft report which was revised in the final report.

A question arises as to whether the VA should continue to have the authority for providing Federal funds for developing new medical schools or increasing the capacity of existing medical schools, when many believe we may be training too many physicians. As stated earlier and in keeping with the emerging consensus of numbers of physicians, we plan to request deletion of those provisions relating to both the support of new medical schools and the expansion of existing ones. At the same time, statutory authority will be sought permitting the VA's broader participation in community based primary care programs and in the training of allied health personnel supportive of the primary care effort.

It is requested that budget data recorded in the "Role of the Veterans Administration" section of Chapter 3 include the appropriation and obligation figures for all supporting funds. It is suggested that the second sentence, paragraph 5, of this section read:

> "In addition, VA awarded a total of 15 grants to existing medical schools and 102 grants to programs for education in other health professions and occupations to assist them in expanding and improving their capacities for educating health professional students."

Mr. Gregory J. Ahart
Director, Human Resources Division
U.S. General Accounting Office

The General Accounting Office documentation of the expressed concern of the Congress and the medical profession is valuable and you can be assured that the final report detailing the problems and improvements needed in training an appropriate mix of physician specialists will have my personal attention and that of my staff.

Sincerely,

Max Cleland

MAX CLELAND
Administrator

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

JUL [illegible]77

Director
Human Resources Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

We have reviewed your draft report of April 25, 1977 entitled "Problems in Training An Appropriate Mix of Physician Specialists" (OSD Case #4605) and have no objections to the draft.

Robert N Smith, MD

Robert N. Smith, M.D.

COORDINATING COUNCIL ON MEDICAL EDUCATION

Member Organizations

[illegible]

Office of the Secretary

[illegible]

June 15, 1977

Mr. Gregory J. Ahart, Director
Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Coordinating Council on Medical Education (CCME) has been considering seriously the GAO Draft Report to the Congress entitled, "Problems in Training an Appropriate Mix of Physician Specialists." This reply to your invitation to respond to the Draft Report is not a critique of the details of the Report, since each of the five parent organizations of the CCME will, as you requested, undoubtedly provide their individual responses directly to you.

In addition to the quality of medical education at all levels, one of the CCME's abiding concerns has been the public's perception of the geographic and specialty maldistribution of physicians, and consequently, it has been studying these problems extensively. For example, the CCME's position that 50% of all graduating physicians should be trained in the primary care specialties has made a substantial effect on medical education and the profession to date. Medical students, medical schools, hospital training programs and the specialty boards are all responding to the call for more primary care physicians.

We agree with the Draft Report's position that additional detailed information is needed on which to predicate future needs and policies. Much data on the topic of physician distribution already have been accumulated and are presently available to the Federal government, the profession, and the public at large. Extensive correlation and analysis of data on the public needs for general versus specialized medical care will be required before appropriate recommendations can be drafted to serve as a rational basis for a national policy for training an appropriate mixture of physicians.

GAO Note: The page number cited in this appendix refers to a draft of this report and does not correspond to the page number in the final report.

The CCME agrees with the GAO recommendations that the CCME accept the responsibility for collecting the necessary information, analyzing and correlating the data, and making recommendations for the education and training of physicians, insofar as the CCME already has responsibility for policymaking regarding the education and training of physicians. With the collective strengths of the five parent organizations of the CCME, such a responsibility is appropriate. Indeed the CCME was formed for the purpose of coordinating all aspects of medical education: undergraduate, graduate, and continuing.

The CCME firmly believes

(1) That the needs of the nation for various kinds and numbers of medical specialists may be analyzed within reasonable limits;

(2) that the provisions in Items 1 and 2 on page 108 of the Draft Report are overly simplistic and are inadequate to provide a reasonably accurate assessment of the nation's need for physicians;

(3) that the accreditation process in graduate medical education is devoted solely to considerations of quality, and that accreditation should not be used to control either numbers or kinds of specialty training programs;

(4) that CCME should attempt to achieve the desired goal of matching the ongoing production of physicians to the changing needs in the country for medical care without the difficulties and implications involved in regulation, either by the government or by any organization in the private sector;

(5) that the CCME should determine the impact of physician extenders on the number and type of physicians needed;

(6) that in view of the ongoing activities of the CCME as stated above and the probability of duplicative and possibly conflicting activities, the CCME recommends that the continuation of GMENAC be reconsidered; and

(7) that the recommendations in the Draft Report should be revised to reflect the above convictions of the CCME.

Finally, we appreciate the opportunity which the GAO has given to the CCME to consider and respond to the Draft Report. We assure you that these problems are constantly before us, and we hope that it will be possible for the recommendations in the Draft Report to be revised along the lines suggested above. The CCME intends to continue in an appropriate leadership role in helping to solve problems in the distribution of medical care.

Sincerely yours,

H. Robert Cathcart
Chairman

HRC:yj

American Hospital Association

J. ALEXANDER McMAHON
President

June 22, 1977

Dear Mr. Ahart

The American Hospital Association has carefully reviewed the GAO draft report to the Congress entitled "Problems in Training and Appropriate Mix of Physician Specialists." We support the comments and recommendations contained in the letter from the Coordinating Council on Medical Education (CCME).

We would like to add an additional recommendation. In Recommendations One, Two, and Three on Page 108 of the draft report, the assumption is made that knowledge and methodologies exist for determining the appropriate numbers of physician specialists in ratio to the population and, therefore, can be used to determine physician output.

We challenge the assumption that the need for numbers of different physician specialists can be readily determined. Variances in health care delivery systems, physician productivity, geographical distribution, payment arrangement, length of training, and mix of allied health professions are examples of just a few variables that bear on physician distribution. The matter is further complicated by the length of education required for physicians. Increases and limitations in supply require at least eight years for the results to occur.

In light of the complexity of the issues, we propose that federal funds might best be spent in conducting a feasibility study to determine the means for assessing population needs for various kinds of physician specialists and

GAO Note: The page number cited in this appendix refers to a draft of this report and does not correspond to the page number in the final report.

for recommending ways to govern the supply. We urge that this feasibility study by the CCME be a part of your recommendations.

Thank you for the opportunity to review and comment on the report before it is sent to Congress and the Secretary of HEW.

Sincerely yours

J. Alexander McMahon

cc: Jackson Riddle, M.D.

AMERICAN BOARD OF MEDICAL SPECIALTIES

GLEN R. LEYMASTER, M.D.
Executive Director

JAMES L. HANSEN, M.D.
Associate Director

[illegible]

June 28, 1977

Mr. Gregory J. Ahart, Director
Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The American Board of Medical Specialties is pleased to comply with the invitation to respond to the General Accounting Office draft report "Problems in Training an Appropriate Mix of Physician Specialists."

The American Board of Medical Specialties has as its primary membership the twenty-two boards which certify physician specialists and five associate members, all of which are national organizations with major concerns in medical education, certification and licensure.

In accord with the request of the General Accounting Office staff, copies of the draft report were submitted to each Member Board. After some delay, a copy was obtained and submitted to each member of the American Board of Medical Specialties' Executive Committee.

Unfortunately, the forty-five days allowed did not permit a consolidated response representing a consensus of even a majority of the boards. The American Board of Medical Specialties has, therefore, suggested that each Board respond directly to the General Accounting Office if it wishes to do so. However, all specialty boards consider their primary responsibility the evaluation of the individual candidate--the quality and adequacy of his or her training, knowledge and experience. Many boards believe that concerns about supply and distribution should be kept separate from the evaluation of individual physician's qualifications, and thus may prefer to leave questions of optimum numbers and distribution of physicians to others.

The American Board of Medical Specialties shares with its Member Boards a predominant concern with evaluation and certification of individual physician's qualifications for providing health care of high quality. However, the American Board of Medical Specialties as one of the parents of the Coordinating Council on Medical Education, Liaison Committee on

GAO Note: The page numbers cited in this appendix refer to a draft of this report and do not correspond to the page numbers in the final report.

Graduate Medical Education, and Liaison Committee on Continuing Medical Education, shares with the other founders broader responsibilities for medical education and training. These responsibilities and concerns include the overall influence of the medical educational programs at all levels on all phases of health care.

As a member of the Coordinating Council on Medical Education, the American Board of Medical Specialties, through its representatives, has participated in the development of the Coordinating Council position as stated in the June 15, 1977 letter to you from the Chairman of the Coordinating Council. While time does not permit evaluation by the American Board of Medical Specialties governing assembly, the officers are confident that the American Board of Medical Specialties will support the principles expressed, including but not limited to the following section:

"That CCME should attempt to achieve the desired goal of matching the ongoing production of physicians to the changing needs in the country for medical care without the difficulties and implications involved in regulation, either by the government or by any organization in the private sector."

However, the American Board of Medical Specialties had taken action, prior to the receipt of the General Accounting Office Report, which expressed its belief in a probable additional role for the Coordinating Council on Medical Education, beyond a passive one of data collection and analysis, to include a possible regulatory role in the distribution of residency positions in all specialties. The American Board of Medical Specialties believes that the Coordinating Council on Medical Education should assume a strong leadership role which probably can be discharged only by assuming responsibility for monitoring the size, number and distribution of training programs.

The American Board of Medical Specialties believes that the Coordinating Council on Medical Education should discuss with the Secretary, Health, Education and Welfare, ways by which the Coordinating Council may attempt to achieve the desired goal of matching the production of physicians to the needs of the country. Contractual arrangements with the Department, however, may not be the best way of establishing responsibility and securing the means of carrying out that responsibility. Alternatives should be considered.

A few specific criticisms of the draft report follow:

(1) The emphasis on physician to population ratios throughout the report suggests oversimplified solutions to the manpower problems. At the very least, the report should provide for consideration of other approaches (see page 108, #1, 2, for examples).

(2) The *Table of Medical Specialists and Subspecialists Certified By The Specialty Boards,* following page 31 of the draft, is misleading in its identification of specialties and subspecialties. The *General Certifications* (primary) and *Special Certifications* are shown in Table 1, pages 2 and 3 of the Annual Report of the American Board of Medical Specialties, 1976-77, which accompanies this letter. *The American Medical Dictionary* uses a somewhat longer list, but that list includes specialties and subspecialties not certified by any of the twenty-two primary and conjoint boards recognized by the American Board of Medical Specialties and the American Medical Association. To the above referenced table should be added the Special Certification of *Pediatric Endocrinology* (9-77).

(3) Finally, the report should recognize the risk to the Coordinating Council if it follows the course recommended by the General Accounting Office and should indicate ways of minimizing the possibility of adverse actions by governmental agencies other than Health, Education and Welfare. The General Accounting Office proposed regulation by the Coordinating Council on Medical Education of numbers and specialty distribution seems closely related to the several activities of medical associations and specialty boards which are now, or recently have been under attack by the Federal Trade Commission and/or the Justice Department.

We appreciate the opportunity to comment on this report. The problems with which it deals are important ones for the welfare of the nation. The American Board of Medical Specialties will do its part in helping to find solutions.

Yours sincerely,

John C. Beck, M.D., President

Glen R. Leymaster, M.D., Executive Director

JCB/GRL/jem

cc: Executive Committee, ABMS
James Sammons, M.D., AMA
J. Alexander McMahon, AHA
Richard Wilbur, M.D., CMSS
John A.D. Cooper, M.D., AAMC
Jackson Riddle, M.D., CCME

association of american
medical colleges

[illegible]
[illegible]

[illegible]

July 11, 1977

Mr. Gregory J. Ahart
Director
Human Resources Division
United States
General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

Many thanks for the opportunity to review the draft GAO proposed report on "Problems in Training An Appropriate Mix of Physician Specialists." Several members of our staff have read and commented on the manuscript and a precis of it was presented to the Administrative Boards of the Council of Deans, Council of Teaching Hospitals and Council of Academic Societies of the Association of American Medical Colleges. The Association's Executive Council, on the basis of the responses of these bodies, approved at its meeting on June 24, 1977 the recommendation that the AAMC:

- "Support the proposal in the GAO Report that the CCME accept the responsibility for recommending the appropriate distribution of residencies among the specialties of medicine, but not for carrying out or enforcing these recommendations;
- Recommend to the Secretary, DHEW that the Graduate Medical Education National Advisory Council (GMENAC) be abolished when and if the CCME accepts the proposal;
- Recommend that the development of regulatory apparatus be deferred until obviously needed;
- Recommend that, should regulatory apparatus be required, the CCME be invited to participate in its design.
- Recommend that, should regulatory apparatas be required, it be effected by mechanisms that are completely separate from the LCGME accreditation process."

You will note that the AAMC position is that the CCME should carry out all elements of the program proposed for it in the recommendation of the GAO Report except the actual regulatory function. It was felt that so long as events continue to evolve in a socially desirable direction as a result of the spontaneous

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and voluntary acts of individuals in the system, additional action can be held in abeyance. Once created, enforcement mechanisms are seldom abandoned; therefore, the nation should try to postpone the birth of any new regulatory body until a need for it is widely perceived.

Enclosed is a more detailed review of the report, prepared by the AAMC staff. I hope it is helpful. If I may be of further assistance, please do not hesitate to call upon me.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

Attachment

GAO Note: AAMC's supplementary comments were incorporated in the report where appropriate.

[illegible]

July 29, 1977

Mr. Gregory J. Ahart, Director
Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The American Medical Association appreciates this opportunity to submit its reactions to the draft report of the General Accounting Office on the "Problems in Training an Appropriate Mix of Physician Specialists." Attached is our response which is in three sections: General Comments, Observations and Conclusions regarding the Draft Report, followed by a Critique of Certain Details in the Draft Report.

We trust that our comments, criticisms, and recommendations will be given serious consideration by the General Accounting Office, and that the AMA comments will be incorporated in the Final GAO Report.

The American Medical Association will continue to participate in the study of ways and means for providing an optimum level of medical services and in the development of strategies by which this objective may be fulfilled.

Sincerely yours,

James H. Sammons, M.D.
James H. Sammons, M.D.

JHS:yj
Attachment

THE AMERICAN MEDICAL ASSOCIATION
RESPONSE TO THE GAO DRAFT REPORT ON

"PROBLEMS IN TRAINING AN APPROPRIATE
MIX OF PHYSICIAN SPECIALISTS"

GENERAL COMMENTS

We have reviewed the recommendation in the GAO Draft Report that HEW enter into a contract with CCME "for developing and implementing a system for seeing that the number and types of physicians being trained is consistent with the approximate number needed in the Nation." It is the opinion of the American Medical Association that regulation of the supply of physicians and their specialties by government or professional organizations, as suggested by the Draft Report, would have an unpredictable and detrimental impact upon the future quality of health care. We believe that the public interest can best be served under a system which maximizes the freedom of individuals to choose their own careers under normal competitive conditions.

The Draft Report implies that the number and types of physicians for future "needs" can be easily determined by statistical and survey methods. The "demand" for medical services depends to large measure upon the extent to which the individual or government or other third parties are willing to pay for health services on his behalf. If "need" is to be the criterion for controlling the physician population it should be recognized that a significant segment of the nation's population is not receiving medical attention (for various reasons) which could extend life or improve its quality. The "need" or the extent to which people might benefit from medical services provided by government without "cost" to the patient (other than through general taxation) is without limit. The future indicates that the social policy developed by legislators and not physicians will determine what types of medical needs will be recognized to the exclusion of others.

The American Medical Association believes that neither physicians nor other health professionals should be subject to government or organizational controls as to number or type. Other occupations are not subject to such controls and in a democratic society, the freedom to choose a career in a competitive environment should be protected to the maximum degree.

The position of the AMA is that regulation of the number and type of physicians as suggested by the Draft Report would not serve the public interest.

Medical specialties and particularly subspecialties are not rigidly separated disciplines, but to the contrary permit flexible adjustment to changing technology and demands of medical practice.

OBSERVATIONS AND CONCLUSIONS

The American Medical Association's most serious concern with the GAO Draft Report is that the data included in the Draft Report do not support the allegations and the recommendations made in the Draft Report. Despite repeated assertions in the GAO Draft Report that the present system of physician distribution needs to be changed, the Draft Report does not establish any deficiencies or flaws in the present system of physician production based on the responses of either the medical organizations or the public health authorities which were questioned by the GAO. By contrast, the text of the Report contains statistical evidence which confirms our contention that, although somewhat imperfect, the present system functions adequately through the efforts of the profession in response to perceived needs of the public, without the necessity for legal restriction or direction. The imperfections in the present complex system have been identified already and are being addressed. For example, the need for more primary care physicians has stimulated remedial actions by a variety of interested organizations including state governments.

We agree with the statements in the Draft Report that factual information must be developed in order that better planning and recommendations may be made for the future. Through the CCME, and independently, the AMA has been involved aggressively in the collection and the analysis of data pertinent to the subject of physician distribution. Data which have not been correlated also exist in the repositories of the Federal government; extensive studies of such information should be pursued. These data need to be analyzed, correlated, and their interrelationships studied against lists of possible variables and such other factors as might be predicted.

The public's need for services of physicians should be assessed first, and the result should be balanced against presently available and predictable sources of physician services. Any inequities or discrepancies thus revealed could be the subject of recommendations for correction. However, this approach does not consider any changes in physician productivity which may occur, and it assumes that physicians function in fixed proportions in the delivery of medical care. Also, it does not take into account possible changes in medical technology or public health practice as the result of scientific breakthroughs.

Furthermore, changes in practice rapidly effect changes in needs. In order to understand the complexities involved, it is only necessary to remember (1) the changed need for vascular surgeons as the result of the development of procedures for coronary bypass surgery, or (2) the impact of the techniques for joint replacement on the practice of orthopedic surgeons and on rehabilitative services, or (3) the demand for more diagnostic radiologists as the result of the development of computerized axial tomography. Other variables, such as major changes in the economy of the country, or the kind of program of national health insurance that might be developed, also could produce severe distortions in the public's need for medical services and make impossible accurate projections for the distribution of physicians by specialty.

We question whether the stated needs for physicians and a different distribution of physicians by specialty is truly reflective of the opinions and needs of the public, or whether these perceived needs are merely purveyed to the public and emphasized in order to convince them that they are medically underserved. Many surveys have shown that over 80% of the public are satisfied with the medical care they now receive; this represents a higher level of satisfaction of the public than for many other factors in their lives.

We are disturbed that the Draft Report is based on opinion and hearsay from individuals styled as authorities but who are not identified. Furthermore, the polls of the organizations and individuals were taken approximately two years ago and the picture has changed remarkably in that time. Not only has there been an increasing production of physicians in the expanded and new medical schools in the United States, but also there has been a significant change in the numbers of physicians going into the primary care specialties. If one includes the specialty of Obstetrics and Gynecology in primary care, as do both the CCME and the AMA, then the proportion of medical school graduates now going into the primary care specialties is over 60%.

If the true picture is elicited through complex and thorough analysis of existing and new data, and if these facts are widely publicized to the general public and to all components of the medical profession with appropriate recommendations, we firmly believe that medical students, training program directors, hospital administrators, and medical school deans will react to modify the availability of medical services with resultant improvements in the distribution of medical manpower. Legal rigidity tends to freeze the situation and prevents rapid adaptability to the necessary changes and modifications by other factors. For this reason we strongly believe that rigid controls are to be avoided.

The American Medical Association has long recognized that it has a legitimate, proper concern for, and a major responsibility to oversee, the quality of medical education and to provide a continuing supply of well-qualified physicians to meet the medical manpower needs of the public. Indeed, at the time of the founding of the AMA in 1847, this responsibility was placed in a Committee on Medical Education which achieved full status as an AMA Council in 1904. Chapter XIII, Section II(A) of the AMA Bylaws stipulates that among the functions of the Council on Medical Education shall be the responsibility "for the provision of a continuing supply of well-qualified physicians to meet the medical manpower needs of the public."

We believe that sound planning for the future delivery of medical care to the people of this country should be led primarily by the profession which is chiefly involved and most knowledgeable in this area, rather than the Federal government. It is our strong belief, based on available evidence, that regulatory controls over the graduate training of physicians are neither necessary nor wise. Therefore, neither the CCME, nor any agency, private or governmental, should be given a legislative mandate to regulate the supply of physicians by specialty or geographic location. Therefore, the AMA will continue to participate, individually and through the CCME, in the study of our nation's needs for medical services, and in the development of strategies by which those needs may be fulfilled.

GAO Note: AMA's supplementary comments were incorporated in the report where appropriate.

CMSS council of medical specialty societies
REPLIES TO P.O. BOX 70
LAKE FOREST ILLINOIS 60045
[illegible]

August 2, 1977

Mr. Gregory J. Ahart
Director, Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

On behalf of the member societies of the Council of Medical Specialty Societies, I am pleased to submit to you the attached coordinated response to the GAO Draft Report, "Problems in Training an Appropriate Mix of Physician Specialists".

The CMSS coordinated response represents careful analysis of our copies of the responses by 13 of our 20 member organizations (see attached list). One society, the American Association of Neurological Surgeons, is currently in process of responding. We have just learned that the copy of the GAO Draft Report we sent to them went astray and a second copy has been forwarded. The coordinated response was approved at our July 27 CMSS Assembly meeting. A supplement is appended which contains specific comments of CMSS member societies, grouped by topic.

Once again, we congratulate the GAO for its diligence in examining the critical issue of physician manpower availability and national needs. We feel quite confident that this Report, when released, will prove its value by stimulating positive action toward solving many of the problems highlighted in the Report.

Sincerely,

Richard S. Wilbur, M.D.
Executive Vice President

RSW:fmp
Attachments (3)

GAO Note: The page numbers cited in this appendix refer to a draft of this report and do not correspond to the page numbers in the final report.

AMERICAN ACADEMY OF DERMATOLOGY
AMERICAN ACADEMY OF FAMILY PHYSICIANS
AMERICAN ACADEMY OF NEUROLOGY
AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
AMERICAN ACADEMY OF PEDIATRICS
AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION
AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
AMERICAN COLLEGE OF PHYSICIANS
AMERICAN COLLEGE OF PREVENTIVE MEDICINE
AMERICAN COLLEGE OF RADIOLOGY
AMERICAN COLLEGE OF SURGEONS
AMERICAN PSYCHIATRIC ASSOCIATION
AMERICAN SOCIETY OF ANESTHESIOLOGISTS
AMERICAN SOCIETY OF COLON AND RECTAL SURGEONS
AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS
AMERICAN UROLOGICAL ASSOCIATION
COLLEGE OF AMERICAN PATHOLOGISTS
SOCIETY OF THORACIC SURGEONS

CMSS COMPONENT SOCIETIES RESPONDING TO THE U.S.G.O. DRAFT REPORT:

1. AMERICAN ACADEMY OF DERMATOLOGY
2. AMERICAN ACADEMY OF FAMILY PHYSICIANS
3. AMERICAN ACADEMY OF OPHTHALMOLOGY, A DIVISION OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
4. AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
5. AMERICAN ACADEMY OF PEDIATRICS
6. AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION
7. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
8. AMERICAN COLLEGE OF PHYSICIANS
9. AMERICAN COLLEGE OF PREVENTIVE MEDICINE
10. AMERICAN COLLEGE OF SURGEONS
11. AMERICAN PSYCHIATRIC ASSOCIATION
12. AMERICAN SOCIETY OF ANESTHESIOLOGISTS
13. AMERICAN SOCIETY OF COLON AND RECTAL SURGEONS

COORDINATED RESPONSE OF 13 CMSS MEMBER SOCIETIES TO U.S. GAO DRAFT REPORT.

"PROBLEMS IN TRAINING AN APPROPRIATE MIX OF PHYSICIAN SPECIALISTS"

Analysis of the responses of 13 CMSS societies shows strong support for the GAO recommendation that the Coordinating Council on Medical Education (CCME) assume responsibility for developing and implementing a system for seeing that the number and types of physicians being trained is consistent with the approximate number needed in the nation. The principal disagreement with this CCME role was as to whether the regulatory function of physician manpower production should be a part of this process. Half of those commenting on the regulatory aspect of the recommendation favored the CCME assuming this function, while the other half felt that the CCME should assume this responsibility but should not be a regulator. Two societies had no comments on this issue, while one objected to the CCME being involved in any facet of regulating physician manpower production and stressed the difficulty of identifying "need". A consensus was apparent among these respondents: the belief that any recommendations concerning the numbers and types of physicians produced should be voluntarily achieved through efforts of those in the private sector responsible for graduate medical education and training, and not under regulations promulgated by HEW. Several responding societies were in favor of leaving control to the free market mechanism.

Two organizations expressed concern with FTC attitudes toward regulation by the profession of the number of physicians produced. Both felt that until these concerns were clarified that the GAO recommendation in regard to the CCME was moot, perhaps even inappropriate. Two responding societies cautioned against tying regulation of physician manpower into existing accreditation mechanisms.

A general consensus is that the Draft Report is correct in its assumption that the Coordinating Council on Medical Education is the best available organization to assume responsibility for overseeing the number and types of physicians being trained, in order to attempt to ensure that these are sufficient for the optimal health care of the American people. The Coordinating Council on Medical Education has, as its parent organizations, those bodies best able to obtain the information and to implement any necessary changes. Furthermore, these are fitting responsibilities for those parent organizations. The consensus amongst the CMSS member societies has been that this mechanism will be most effective and responsive if it remains within the private sector and does not become a portion of the regulatory mechanism of the Federal government.

If, for some reason, the Coordinating Council on Medical Education is unable to assume the responsibility for overseeing this complex situation, the CMSS would urge that other alternatives be considered before turning this matter over to the public sector.

A. RELATED CONSIDERATIONS: As might be expected, the CMSS societies who responded provided additional comments on the GAO Draft Report involving a broad spectrum of topics.

1. Physician/Population ratios. Ten of the thirteen CMSS societies offered comment on physician/population ratios, obviously stimulated by the Draft Report statements connected with the Table of Physician Population Estimates appearing on page 44. Two specialties not indicated in the Table provided ratios as follows: Dermatology - 3.2 physicians per 100,000 population; Pediatrics - 1 physician to 2,000 to 2,500 population.

   One specialty, Family Practice, supported development of physician/population ratios, while two, Ophthalmology and Preventive Medicine, stated that physicians were in undersupply in their specialties without offering a ratio. Three specialties, Surgery, Obstetrics/Gynecology, and Anesthesiology, expressed mild or strong objection to the use of physician/population ratios. These criticisms ranged from ratios not being a reliable guide to adequacy of medical services for the population, to their being too simplistic in their approach to be effective, or not being adaptable to predicting an appropriate physician mix. Psychiatry offered information contradicting the validity of the statistics in the Draft Report regarding the future manpower needs of that specialty.

2. Primary Care. Primary care was a subject of considerable comment, particularly relating to the observation on page 18 of the Draft Report that "a primary care physician can take care of up to 85% of the problems for which people seek care".

   a) Primary care and specialties:
   Nine societies stated opinions regarding their involvement in primary care. Obstetrics/gynecology, generally considered by health planners as a primary care specialty (along with internal medicine, family physicians, and pediatrics), strongly supported the inclusion of obstetrics/gynecology as a primary care specialty. Psychiatry, Ophthalmology and Dermatology all voiced the belief that they, too, should be considered primary care providers, while Pediatrics presented what they consider a viable alternative to the family physician rendering primary care "..that of the pediatrician and internist working as a team to provide comprehensive continuous care to the family".

   b) Primary care and quality:
   This subject was addressed by three specialties. Surgery felt that quality could not be accomplished by "generalists" carrying out complicated surgical procedures. Family Physicians stated that "determination of the number and types of physicians required to fill national needs should never be at the expense of the quality of medical care provided". Dermatology felt that quality was being sacrificed in an attempt to identify primary care providers by specialty without regard to the demonstrated value of specialization in non-primary care areas which, it stated, resulted in lower cost care to the patient in terms of morbidity and dollars for specific types of diseases.

A. 2. c) Primary care and health care needs — definition and study: Throughout the comments there was strong sentiment expressed by most of the responding organizations concerning the need to better define what constitutes primary care and for a comprehensive study by the specialties of both manpower and health care needs. These specialties supporting these suggestions were: Family Practice, Dermatology, Ophthalmology, Psychiatry, Anesthesiology, and Preventive Medicine.

Societies indicating that they are initiating, or have just completed, manpower studies are: The American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Ophthalmology, a division of the American Academy of Ophthalmology and Otolaryngology.

B. PHYSICIAN EXTENDERS: Most of the responding societies had strong feelings about the use of physician extenders as they relate to physician manpower numbers and needs. One society felt that the Draft Report placed little emphasis on the increasing role of non-physician personnel and physician extenders in the total consideration of manpower needs. It questioned the availability of data on numbers and activities of nurse practitioners, for example. Another objected to the HEW Secretary determining the number of physician extenders, suggesting that each discipline should be responsible for this determination in consultation with the appropriate "extenders" within the specialty. Another suggested that the provision of health care by physicians and their extenders must be considered as a single entity in manpower considerations affecting each specialty and suggested that this task be the responsibility of the CCME. Still another strongly supported the report recommendation that the impact of extenders be measured in terms of number and type of physicians needed. It suggested that physician extenders should be considered as medical manpower adjuncts to physicians, rather than substitutes for physicians, and that limits should be set by state regulations on the number of physician extenders allowed to work under the supervision of a physician. Another society is classifying how physician extenders in its specialty can deliver the highest quality health care.

C. NEW GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE (GMENAC): The GAO Draft Report recommended that if the CCME does not accept the role for overseeing constraints in physician manpower, that the Secretary of HEW should assume this responsibility. Several societies commented on this. One felt that GMENAC should be given an opportunity to work with the problem, in view of its relative newness, and that it should utilize the CCME as a resource since it has been addressing manpower problems in an advisory and policy fashion for the past four years. Another supported the CCME response on this issue in which it was suggested that continuation of GMENAC be reconsidered in view of the ongoing activities of the CCME in manpower and the probability of duplicative and conflicting activities with GMENAC. Two others suggested that the CCME, if it accepts the recommended role, establish an advisory committee with representation from each specialty.

D. FOREIGN MEDICAL GRADUATES (FMG's): Three specialties commented on the forthcoming reduced availability of foreign medical graduates subsequent to passage of the Health Professions Educational Assistance Act of 1976 (PL 94-484). It was mentioned that in Pediatrics, FMG's constituted 31% of all residents in training in 1976. In Physical Medicine and Rehabilitation, 70% of all residents currently in training are FMG's. Psychiatry stated that, in 1976, FMG's comprised 39% of 1st year psychiatric residents.

LJC:fmp
8/2/77

APPENDIX XIII

APPENDIX XIII

HEW'S GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE

ROSTER OF MEMBERS

(As of November 30, 1977)

CHAIRMAN

W. Jack Stelmach, M.D.
Director
Family Practice Residency Program
Baptist Memorial Hospital
Kansas City, Missouri

EXECUTIVE SECRETARY

Frederick V. Featherstone, M.D.
Assistant Director for Planning
Division of Medicine
Health Resources Administration
HEW

MEMBERS

Marilyn N. Aguirre, Ms.
Project Director
Identity Development and Education for Adolescents
New York, New York

Mary M. Burnett, D.O.
Dallas, Texas

Robert B. Carbeck, M.D.
Head
Department of Internal Medicine
St. Joseph Mercy Hospital
Ann Arbor, Michigan

Henry A. Diprete, Mr.
Second Vice President
John Hancock Mutual Life Ins. Co.
Boston, Massachusetts

William F. Donaldson, M.D.
Clinical Professor
Orthopedic Surgery
University of Pittsburgh School of Medicine
Pittsburgh, Pennsylvania

William R. Hogarty, Mr.
Executive Director
Puget Sound Health Systems Agency
Seattle, Washington

William D. Holden, M.D.
Director
Department of Surgery
School of Medicine
Case Western Reserve University

Robert A. Kistner, D.O., M.D.
Dean of Faculty
Chicago College of Osteopathic Medicine
Chicago, Illinois

Charles A. Lemaistre, M.D.
Chancellor
The University of Texas System
Austin, Texas

Beverly C. Morgan, M.D.
Chairman
Department of Pediatrics
University of Washington
Seattle, Washington

MEMBERS

Serena Friedman, M.D.
Los Angeles, California

James G. Haughton, M.D.
Executive Director
Health & Hospitals Governing
Commission of Cook County
Chicago, Illinois

Bruce E. Spivey, M.D.
President
Pacific Medical Center
San Francisco, California

Jeanne Spurlock, M.D.
Deputy Medical Director
American Psychiatric
Association
Washington, D.C.

Tom E. Nesbitt, M.D.
Nashville, Tennessee

James A. Pittman, Jr., M.D.
Executive Dean
School of Medicine
The University of Alabama
in Birmingham
Birmingham, Alabama

Eugene L. Staples, Mr.
Director
West Virginia University
Hospital
Morgantown, West Virginia

EX-OFFICIO FEDERAL MEMBERS

Permanent Members

William Mayer, M.D.
Assistant Chief Medical
Director for Academic
Affairs, VA

Robert N. Smith, M.D.
Assistant Secretary of
Defense (Health Affairs),
DOD

Harold Margulies, M.D.
Deputy Administrator, Health
Resources Administration,
HEW

Alternate Members

John Mather, M.D.
Chief of Medical/Dental
Division
Office of Academic Affairs, VA

RADM J. William Cox, MC, USN
Assistant Chief for Human
Resources and Professional
Operations, DOD

PRINCIPAL OFFICIALS RESPONSIBLE FOR ADMINISTERING ACTIVITIES DISCUSSED IN THIS REPORT

FEDERAL AGENCIES	Tenure of office	
	From	To
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE		
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
J. A. Califano, Jr.	Jan. 1977	Present
D. Mathews	Aug. 1975	Jan. 1977
C. W. Weinberger	Feb. 1973	Aug. 1975
ASSISTANT SECRETARY FOR HEALTH:		
J. Richmond, M.D.	July 1977	Present
J. F. Dickson, III, acting	Jan. 1977	July 1977
T. Cooper, M.D.	May 1975	Jan. 1977
T. Cooper, M.D., acting	Jan. 1975	May 1975
C. C. Edwards	Mar. 1973	Jan. 1975
ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION:		
H. A. Foley, Ph.D.	Dec. 1977	Present
K. M. Endicott, M.D.	Aug. 1973	Jan. 1977
ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION:		
G. L. Klerman, M.D.	Nov. 1977	Present
P. N. Waldrop, M.D., acting	Jan. 1977	Nov. 1977
J. D. Isbister	Aug. 1975	Jan. 1977
J. D. Isbister, acting	Sept. 1974	Aug. 1975
DIRECTOR, NATIONAL INSTITUTES OF HEALTH:		
Donald S. Fredrickson, M.D.	July 1975	Present
R. W. Lamont-Havers, M.D., acting	Feb. 1975	July 1975
Robert S. Stone, M.D.	May 1973	Jan. 1975

	Tenure of office	
	From	To
VETERANS ADMINISTRATION		
ADMINISTRATOR OF VETERANS AFFAIRS:		
J. M. Cleland	Mar. 1977	Present
H. D. Grubb, acting	Feb. 1977	Mar. 1977
R. L. Roudebush	Oct. 1974	Feb. 1977
DEPUTY ADMINISTRATOR:		
R. H. Wilson	Mar. 1977	Present
(vacant)	Jan. 1977	Mar. 1977
O. W. Vaughn	Nov. 1974	Jan. 1977
CHIEF MEDICAL DIRECTOR:		
J. D. Chase, M.D.	Apr. 1974	Present
DEPARTMENT OF DEFENSE		
SECRETARY OF DEFENSE:		
H. Brown	Jan. 1977	Present
D. H. Rumsfeld	Nov. 1975	Jan. 1977
J. R. Schlesinger	July 1973	Nov. 1975
SECRETARY OF THE AIR FORCE:		
J. C. Stetson	Apr. 1977	Present
T. C. Reed	Jan. 1976	Apr. 1977
J. W. Plumner, acting	Nov. 1975	Jan. 1976
J. L. McLucas	June 1973	Nov. 1975
SECRETARY OF THE ARMY:		
C. L. Alexander, Jr.	Feb. 1977	Present
M. R. Hoffman	Aug. 1975	Dec. 1976
N. R. Augustine, acting	July 1975	Aug. 1975
H. H. Callaway	May 1973	July 1975
SECRETARY OF THE NAVY:		
W. Graham Claytor, Jr.	Feb. 1977	Present
J. Wm. Middendorf, II	June 1974	Feb. 1977

APPENDIX XIV

APPENDIX XIV

Tenure of office
From To

MEDICAL PROFESSION

COORDINATING COUNCIL ON MEDICAL EDUCATION

CHAIRMAN:	1977
H. R. Cathcart	1976
C. Rollins Hanlon, M.D.	1975
Jack D. Myers, M.D.	1974
Tom E. Nesbitt, M.D.	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

PRESIDENT:	1974-1977
John A. D. Cooper, M.D., Ph.D.	

AMERICAN BOARD OF MEDICAL SPECIALTIES

EXECUTIVE DIRECTOR:	1976-1977
Glen R. Leymaster, M.D.	1974-1975
John C. Nunemaker, M.D.	

AMERICAN HOSPITAL ASSOCIATION

PRESIDENT:	1974-1977
J. Alexander McMahon, M.D.	

AMERICAN MEDICAL ASSOCIATION

PRESIDENT:	1977
John H. Budd, M.D.	1976-1977
Richard E. Palmer, M.D.	1975-1976
Max H. Parrott, M.D.	1974-1975
Malcolm C. Todd, M.D.	

COUNCIL OF MEDICAL SPECIALTY SOCIETIES

PRESIDENT:	1977
Richard S. Wilbur, M.D.	1976-1977
Charles H. Herndon, M.D.	1974-1975
C. Rollins Hanlon, M.D.	

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